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Aerospace Medicine

FLIGHT AND OPERATIONAL MEDICINE PROGRAM (FOMP)

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This Instruction implements AFPDs 11-4, *Aviation Service* and 48-1, *Aerospace Medicine Enterprise (AME).* It provides guidance, responsibilities and establishes procedures for the Flight and Operational Medicine Program (FOMP) in support of the overall Aerospace Medicine Enterprise. This publication applies to Air Force (AF) Active Duty (AD), Air Force Reserve Command (AFRC) and Air National Guard (ANG) members and units. Any organizational level may supplement this Instruction. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through Major Command (MAJCOM) publications/forms managers. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) AFMAN 33-363, *Management of Records* and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

SUMMARY OF CHANGES

This document is substantially revised and must be completely reviewed.

Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. Introduction and Overview: This Instruction provides guidance, highlights responsibilities and establishes procedures for the Flight and Operational Medicine Program (FOMP) in support of the overall Aerospace Medicine Enterprise. It focuses mainly around the processes within the Flight and Operational Medicine Clinic (FOMC), the Assistant Surgeon General, Health Care Operations (AF/SG3)-approved *Mission Essential Tasks/Activities for Line Support (METALS)*, and Squadron Medical Element (SME), compiling key concepts from multiple related instructions covering the programs of: Flying, Operational and Special Duty, Occupational and Environmental Health, Medical Force Protection, Community Health Operations, Human Performance Operations, and Emergency Response / Disaster Management.

1.2. Scope: FSs must be completely familiar with all flying and operational activities at their assigned location to effectively provide flight and operational medicine support to the commander.

1.2.1. If a mission or operation is classified, then the aeromedical team to include: Chief of Aerospace Medicine (SGP), Flight Surgeon (FS), Public Health Officer (PHO), Bioenvironmental Engineer (BE), Aerospace Operational Physiologist and Aerospace Operational Psychologist (AOP), should receive appropriate security clearance and be read in to the degree required to provide operational, occupational, environmental, and aeromedical support to the personnel and operation.

1.2.2. Air Force Reserve Component (ARC) Flight and Operational Medicine team members are expected to fulfill all aspects of this AFI when deployed or working in active duty medical facilities, however, ARC medical personnel are generally not privileged nor credentialed to treat beyond self-aid/buddy care when in garrison.

1.2.2.1. The Reserve Medical Unit (RMU) is the in-garrison ARC-equivalent of the active duty Medical Treatment Facility (MTF)

1.3. Organizational Responsibilities.

1.3.1. **The Air Force Deputy Chief of Staff, Operations, Plans, and Requirements (AF/A3/5)**

1.3.1.1. Establishes requirements and policies for Flying, Space and Missile, Cyber Operations and other special operational personnel and squadron operations

1.3.1.2. Prescribes the operational qualification requirements for FS

1.3.2. **Surgeon General** (**AF/SG)** Provides strategic guidance, resources, policies and procedures to execute the FOMP

1.3.3. **Assistant Surgeon General, Health Care Operations** (**AF/SG3)**

1.3.3.1. Provides policy and regulatory guidance necessary to successfully execute the FOMP

1.3.3.2. Oversees strategic planning and programming activities

1.3.3.3. Maintains liaison with Department of Defense (DoD) agencies for aircrew, SMOD and other special operations personnel's health, disease prevention, occupational health, environmental quality and crew performance issues

1.3.3.4. Maintains liaison with AF/A3O on issues concerning SME utilization and Concept of Operations

1.3.3.5. Sets policy for implementation of FS and SME utilization

1.3.4. **Chief, Aerospace Medicine Policy and Operations (AF/SG3P)**.

1.3.4.1. Provides programming recommendations to support strategic guidance of AF/SG

1.3.4.2. Maintains AFMS FOMP METALS list

1.3.5. **Aerospace Medicine Division (AF/SG3PA)**

1.3.5.1. Develops plans and programs and provides consultative services to enable FOMP execution

1.3.5.2. Ensures integration and coordination of FOMP initiatives and policy with Headquarters Air Force (HAF) agencies

1.3.5.3. Provides consultation on all FOMP issues to MAJCOM, HAF, and other agencies

1.3.5.4. Interfaces with all MAJCOM/SGPs to facilitate successful execution of the FOMP

1.3.5.5. Maintains liaison with other Services and Federal agencies

1.3.5.6. Develops objective metrics to measure the success of the FOMP

1.3.5.7. Develops and maintains standardized medical training for all FOMC personnel

1.3.6. **MAJCOM/SG**

1.3.6.1. Organizes, trains and equips personnel to support FOMP execution within their command

1.3.6.2. Assigns a supporting medical treatment facility (MTF(RMU)) for FOMP components at Limited Scope Medical Treatment Facilities (LSMTF), Geographically Separated Units (GSU) and Medical Aid Stations (MAS)

1.3.7. **MAJCOM/SGP**

1.3.7.1. Develops guidance for subordinate installation medical units to properly execute the FOMP

1.3.7.2. Executes MAJCOM/SG waiver authority for aeromedical waivers within delegated authority IAW AFI 48-123 *Medical Examinations and Standards* and delegates to base level SGPs as appropriate

1.3.7.3. Air Combat Command (ACC)/SGP develops a Combat Air Forces (CAF) specific fatigue countermeasures supplement to this instruction addressing FS specific training and responsibilities and fatigue management including operational use of stimulant (Go Pills) and sedative medications (No-Go Pills). Their supplement will comply with this Instruction and the Official Air Force Aerospace Medicine Approved

Medications list. The supplement will also be coordinated with ACC/A3 and AF/SG3P and include both fighter and bomber aircraft.

1.3.7.4. Air Mobility Command (AMC)/SGP develops a Mobility Air Forces (MAF) specific fatigue countermeasures supplement to this instruction and AFI 11-2 *Mission Design Series* (MDS) instructions addressing FS specific training and responsibilities and fatigue management including operational use of stimulant (Go Pills) if applicable, and sedative medications (No-Go Pills). Their supplements will comply with this Instruction, and the Official Air Force Aerospace Medicine Approved Medications list. The supplement will also be coordinated with AMC/A3 and AF/SG3P.

1.3.7.5. Functions as a liaison between the MTF(RMU), medical squadrons or medical groups, and Air Force Medical Support Agency (AFMSA)

1.3.8. **Medical Group Commander (MDG/CC)**. (Reserve Medical Unit (RMU/CC) for AFRC units provide equipment for training of FOMC personnel only)

1.3.8.1. Provides resources, personnel, and guidance to ensure successful execution of the FOMP at their installation

1.3.8.2. Ensures FOMP personnel are trained and resourced to successfully execute the FOMP at deployed locations

1.3.8.3. Ensures FOMC and SME training, supplies, and equipment are provided for home station medical care, (cardio pulmonary resuscitation (CPR), advanced cardiac life support (ACLS), advanced trauma life support (ATLS), national registry of emergency medical technicians (NREMT), on the job training (OJT), etc). This includes funding and preparing orders for Continuing Medical Education (CME) training equivalent to all other providers on the medical staff (Although ARC units generally do not provide home station medical care, their medical providers and technicians still require AFSC-appropriate training for deployment purposes. CME funding is not applicable to ANG and AFRC).

1.3.9. **MTF/SGP**

1.3.9.1. The SGP is appointed in writing by the MDG/CC IAW AFI 48-101, *Aerospace Medicine Operations*. This individual must be a credentialed active duty FS (or ARC FS, for ARC units) and must have privileges in flight medicine at the active MTF. *Note: ANG MDG/CC appoints the SGP in writing, and this individual must be a credentialed flight surgeon (FS) and must have privileges in flight medicine.*

1.3.9.2. The SGP, oversees the AME programs, coordinates aerospace medicine activities to include integration of local Aerospace Operational Physiology Team (AOPT) and AOPs, and maintains operational oversight for FOMC personnel. These programs directly support the Line of the Air Force (LAF) mission ensuring a healthy and fit force, preventing injury and illness, restoring health, and optimizing and enhancing human performance. See AFI 48-101, for specific roles and responsibilities.

1.3.9.3. Will develop a local prioritized list of METALS and an annual execution and monitoring plan

1.3.9.4. Ensures assigned FSs (SME and MDG) complete and maintain required training and experience to the Fully Mission Capable (FMC) level

1.3.9.5. Ensures assigned FS, technicians, and SME personnel are trained on military physical exams and standards

1.3.9.6. Assigns duties and monitors duty performance of FSs and Aerospace Medical Service technicians (4N0X1) including SMEs when not deployed

1.3.9.7. Facilitates and ensures the MTF(RMU) and SME 4N0X1/C complete required tasks and knowledge items identified in the 4N0X1 Career Field Education and Training Plan (CFETP) and Master Task List (MTL) for SMEs

1.3.9.8. Serves as the MDG's senior profile officer and chairs the DAWG. Note: See AFI 10-203, *Duty Limiting Conditions* for further information regarding the DAWG

1.3.9.9. Provides training for the medical staff on medical examinations and standards, to include profiling procedures as described in section 4.3.1.

1.3.9.10. Serves as the local aeromedical certification and waiver authority when so designated by MAJCOM/SGP

1.3.9.11. Serves as the installation subject matter expert on medical standards and physical qualifications. The SGP is the installation focal point in handling matters of medical standards application and resolving problems associated with conducting assessments, documentation and required follow-up of complicated or sensitive cases, and other matters that may call for resolution.

1.3.9.12. Serves as the senior leader, maintaining operational oversight of the MSME and appoints the MSME manager/lead (SrART)

1.3.10. **Aerospace Medicine Squadron/CC or Equivalent.** Management of the SME and MTF(RMU) FS activities in support of the AME will follow established principles of program management to include:

1.3.10.1. Establishes clear objectives and goals for the FOMC

1.3.10.2. Defines tasks and responsibilities necessary to achieve the objectives of the FOMC

1.3.10.3. Specifies clear and reasonable timelines

1.3.10.4. Ensures accountability

1.3.10.5. Reassures effectiveness of reaching the objectives and desired effects

1.3.10.6. Redirects local plans, policy, and practices as needed to better achieve desired effects

1.3.10.7. Ensures quality of medical examination process

1.3.10.8. Retains administrative and Uniform Code of Military Justice (UCMJ) authority over MTF(RMU) assigned FOMC personnel

1.3.10.9. Addresses conflicting requirements or priorities for SME personnel with the SGP, (or flying squadron commander if the Aerospace Medicine Squadron/CC is also the SGP)

1.3.11. **Flying or Operational Squadron/CC**

1.3.11.1. Retains administrative and UCMJ authority over SME personnel, but day to day operational oversight is under the supervision of the SGP while in garrison. SME rating chain will be through the flying or operational squadron. While deployed, SME personnel should integrate with a fixed medical unit if available on the same base or in reasonably close proximity in order to provide seamless deployment health support to the population at risk (PAR). (Exceptions may include: Air Force Special Operations Command (AFSOC) assigned personnel and the Combat Search and Rescue Medical Element (CSARME))

1.3.11.2. SME personnel may compete for quarterly and annual awards within their unit of assignment. SME personnel may also compete for AFMS annual awards via the MDG with SGP recommendation/approval routed through MAJCOM.

1.3.11.3. Provides all administrative functions for assigned SME personnel including personnel actions in the Military Personnel Data System (MILPDS), leave, temporary duty (TDY), work details, or other personnel actions approval.

1.3.11.4. Coordinates leave and TDY requests with SGPs to prevent adverse impact to home station medical operations.

1.3.11.5. Ensures required SME training, supplies and equipment are provided for direct operational support.

1.3.11.6. Prepares orders and arranges funding for deployments and TDYs directly supporting flying operations (e.g. aircraft-specific training, survival training, and mishap investigations). Flying squadron may fund CME training needed for training and certification.

1.3.11.7. Maintains a supply account with the Medical Logistics function and purchases medical supplies for SME deployment kits.

1.3.11.8. Provides individual equipment items, flight gear and deployment bags. Maintains SME mobility folders and tracks mobility requirements.

1.3.11.9. Coordinates requirements for medical support with MTF(RMU). Conflicting requirements or priorities for SME personnel are addressed at the lowest level possible between medical and operational unit leadership, and elevated to higher levels for resolution if required.

1.3.12. **MDG Career Field Functional Managers (CFM)**

1.3.12.1. Responsible for professional development and career progression for Health Services Management (4A0X1), Public Health (PH) (4E0X1) and 4N0X1/C technicians assigned to FOMC including SME 4N0X1/C.

1.3.12.2. Coordinates with SGP ensuring technicians complete required CFETP and MTL items.

1.3.12.3. Coordinates training ensuring technicians meet and maintain requirements for respective career field.

1.3.12.4. Provides recommendation to SGPs on movement of technicians into and out of SME positions and assignment of medical duties based on needs of flying squadron, MTF(RMU)s, and individual development.

1.3.13. **Medical Standards Management Element (MSME) Manager**

1.3.13.1. Integral member of Aerospace Medicine Team at Deployment Availability Working Group (DAWG) and Aerospace Medicine Council (AMC). Acts as a centralized standards consolidation and monitoring body. (See section 4.3 for more details on MSME)

1.3.13.2. Assists MTF(RMU)/SGP or equivalent with DAWG related activities.

1.3.13.3. Ensures physical exams are completed in a timely manner and reports to SGP, or local MTF(RMU) leadership, completion rates and issues impacting completion.

1.3.13.4. Ensures training is completed for use of physical exam systems and waiver actions IAW AFI 48-123 *Medical Examinations and Standards*, and MAJCOM guidance.

1.3.13.5. Ensures profiling actions are completed in a timely manner and duty limiting and/or mobility limiting conditions are reported to unit commanders

1.3.14. **LSMTF Officer in Charge (OIC)**

1.3.14.1. Implements the AME with the assistance of supporting MTF(RMU) designated by MAJCOM/SG IAW AFI 48-101. Overall responsibility of LSMTF AME programs remains with the supporting MTF(RMU)/SGP.

1.3.14.2. Executes AME programs in conjunction with supporting MTF(RMU)/SGP. Provides resources, personnel and guidance ensuring a successful program.

1.3.14.3. Coordinates with local leadership (commanders and supervisors) ensuring obligations, requirements and responsibilities of AME programs are met. These programs directly support LAF mission, ensuring a healthy and fit force, preventing injury and illness, restoring health, and optimizing and enhancing human performance. See AFI 48-101 for specific roles and responsibilities.

1.3.14.4. Ensures responsibilities outlined in functional instructions are completed.

1.3.15. **GSU/CC or delegate (MAS)**

1.3.15.1. Implements AME with supporting MTF(RMU) designated by MAJCOM/SG IAW AFI 48-101. Overall responsibility of AME programs remains with supporting MDG/SGP.

1.3.15.2. Executes AME programs with supporting MDG/SGP. Provides resources, personnel and guidance ensuring program success.

1.3.15.3. Coordinates with local leadership (commanders and supervisors) ensuring obligations, requirements and responsibilities of AME programs are met. These programs directly support LAF mission, ensuring a healthy and fit force, preventing injury and illness, restoring health, and optimizing and enhancing human performance. See AFI 48-101 for specific roles and responsibilities.

Chapter 2

FLYING, OPERATIONAL, AND SPECIAL DUTY PROGRAM

2.1. Objectives and Desired Effects

2.1.1. The flying and other Special Operational Duty personnel (SOD) program's purpose is to optimize the health and performance of aircrew, space, missile, Personnel Reliability Program (PRP), Presidential Support Program (PSP), and other SOD personnel in support of the operational mission of the AF.

2.2. Organization and Functions of the FOMC.

2.2.1. **Empanelment/population served.**

2.2.1.1. Empanels personnel who require maintenance of AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, and may include their respective families. Empanelment may also include Host Aviation Resource Management/Squadron Aviation Resource Management personnel and other flight-related personnel whose care and monitoring is determined by SGP to be best served in the FOMC.

2.2.1.2. Empanelment additions/deletions must be approved/disapproved by the MAJCOM/SGP after request by the MTF(RMU)/CC. Deviations may include enrollment of other operational support groups or personnel with specific occupational exposures determined by the SGP, necessary for successful completion of local aeromedical or installation mission.

2.2.1.3. Members who are on PRP or PSP status will also be empanelled unless there is a stand-alone PRP/PSP clinic. (See 2.3. PRP Element)

2.2.1.4. Will see but not empanel the following categories:

2.2.1.4.1. Active duty and civilian federal employees for occupational health exams, unless there is a stand-alone Occupational Medicine (OM) clinic

2.2.1.4.2. Initial flying, special operational duty physical exams and incentive flight physicals

2.2.1.5. Only the following exams are performed by ANG MDG personnel: annual flying exams, initial flying or special operational duty physical exams, occupational medical exams, PHAs and incentive flight physicals.

2.2.1.6. For AFRC, Aerospace Medicine will provide occupational examinations for military flying and special operational duty personnel only.

2.2.2. **Staffing** (not applicable to ANG)

2.2.2.1. The FOMC will be staffed with FSs (48XX), nurses (46NX), and enlisted personnel, (4A0X1, 4E0X1 and 4N0X1) per current manpower standard.

2.2.2.2. Physician Assistant (PA) (42GX) may also be assigned to assist with primary care, flight/occupational medicine, and preventive medical services.

2.2.2.3. If sufficient AD AF FSs are not available, contract flight medicine physicians (FMPs) may be utilized in the FOMC. A description of expected qualifications and type of work can be found on the AFMS Kx along the following path: Kx home page / Commodity Council / Spiral 1-1-Clinical Acquisition Support Services / Approved Position Descriptions / Flight Medicine Physician. ANG or AFRC FS who are actively credentialed in FOMC may utilize their credentials in FS offices while functioning as a contractor. ANG/AFRC FOMC credentials must be maintained to allow continued function in FS contractor role as detailed IAW AFI 44-119, *Medical Quality Operations* and Guidance Memorandum: *Contract Providers in Flight Medicine* 08 Dec 2006 in the Kx under Aerospace Medicine Signed Documents. Granting and maintenance of credentials will require approval and review IAW AFI 44-119. SGPs will be part of the review process if he/she is not the clinical supervisor.

2.2.2.4. At bases with stand-alone Operational Medicine (OM) clinics, FSs will work with OM clinic staff to maintain clinical competency regarding occupational health exams and industrial shop visits. (not applicable to AFRC)

2.2.3. **Clinical Services Provided**

2.2.3.1. FOMC provides primary and preventive care services to eligible enrollees. Clinical preventive care will be IAW established local policies and priorities outlined by the Population Health Working Group. (not applicable to ANG)

2.2.3.2. FOMC (ANG MDG) performs professional and paraprofessional aspects of flying and SOD health exams, IAW AFI 44-102, *Medical Care Management* and AFI 48-123.

2.2.3.3. FSs/PAs will provide active duty (and civilian federal employees who choose the AF as their medical care for occupational health exams), initial, annual, termination or special purpose occupational evaluations to include Fitness for duty examinations (FSs only) and medical surveillance examinations (MSE), unless there is a stand-alone Occupational Medicine (OM) clinic. (See section 3.2.2.) (not applicable to AFRC)

2.2.3.4. FOMC (ANG MDG) enrolls and provides primary care and preventive services for personnel on active PRP and PSP status unless there is a stand-alone PRP clinic. Personnel who require initial administrative qualification are processed by FOMC or PRP clinic and will remain enrolled there unless denied or until dismissed. (not applicable to AFRC)

2.2.3.5. FSs/PAs will provide preventive medicine services to mitigate travel-related health risks in empanelled population and serve as MTF travel medicine consultants. (ANG MDGs do not provide medical care. (ANG FSs provide appropriate medical prophylaxis and deployment counseling. They do not function as travel medicine consultants, except as related to deployments)

2.2.3.6. FOMC conducts Deployment Health Assessments IAW published standards for enrolled personnel to include enrolled civilian federal employees. (ref AF Kx: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=ctb_146194&functionalArea=WarriorWellness** and DoDI 6490.03 para 2.2 *Deployment Health).*

2.2.3.7. FOMC provides clinical support to MTF patients undergoing evaluation/treatment for communicable disease programs IAW AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance.*

2.2.3.8. FOMC provides care to multi-national forces established in memorandums of agreement or understanding (MOA/MOU), North Atlantic Treaty Organization Standard Agreements (NATO STANAG), or combatant commander (COCOM) directives. (not applicable to ANG/AFRC in garrison)

2.2.3.9. FSs evaluate repatriated Prisoners of War (POWs) IAW current AF and DOD *Repatriation of Prisoners of War Plan*.

2.2.3.10. FSs provide medical care and consultation that may include but not limited to sick call, scheduled clinical appointments, and consults. SGPs collaborate with the MTF(RMU) Group Practice Manager to determine optimal appointment template, ensuring FSs meet both clinical and non-clinical requirements to include METALS and squadron support activities.

2.2.3.11. FOMC updates results of required tests and examinations into the appropriate electronic database/program (PIMR, AF Complete Immunization Tracking Application (AFCITA) / Aeromedical Services Information Management System (ASIMS), Physical Examination Processing Program (PEPP), Aeromedical Information Management Waiver Tracking System (AIMWTS), after the Periodic Health Assessment (PHA).

2.2.3.12. FOMC provides any required follow-ups (including but not limited to Review in Lieu of (RILO) for members on Assignment Limitation Code (ALC)-C, communicable disease, occupational health, deployment surveillance, profile management, and clinical preventive services) on enrolled or assigned patients.

2.2.3.13. FOMC initiates Line of Duty Determination (LOD) AF Form 348, *Line of Duty Determination*, IAW AFI 36-2910 as appropriate.

2.2.4. **FOMC Grounding Management**

2.2.4.1. FOMC conducts the Flight Medicine Working Group (FMWG) as described in **paragraph 2.6.1**.

2.2.4.2. FOMC initiates, tracks, and conducts clinical follow-up reviews for flying and SOD waivers, including entry into AIMWTS see 4.3.2. under MSME. Interim evaluations between waiver renewals will be discussed at grounding management meetings. A 4N0X1(SrART) or 46XX will perform the initial content review of completed aeromedical summaries prior to review by a senior reviewer. SGPs ensure effective waiver management, aeromedical summary quality and timeliness.

2.2.4.3. During in and out-processing, FOMC ensures appropriate grounding management actions are completed (waiver transfer, medication ground testing, medical record review etc).

2.2.4.4. FSs advise flying/SOD commanders on fitness and qualification for flying/SOD activities IAW AFI 48-123. FOMC reports AF Form 1042 actions to flying units on a daily basis by the most expeditious and reliable means.

2.2.4.5. FSs serve as point of contact (POC) for the Soft Contact Lens Program and the Aviation and Aviation Related Special Duty (AASD) Corneal Refractive Surgery group.

2.2.4.6. FSs review medical care provided outside the FOMC no later than the next duty day to render timely aeromedical disposition, (as soon as possible for ANG/AFRC in garrison FSs). Signed and dated aeromedical dispositions must be documented in the Airmen's medical record and communicated to the member's squadron CC via AF Form 1042 as noted in **2.2.4.4**.

2.2.4.6.1. Active Duty FOMCs establish procedures to obtain and review admissions and disposition logs, military emergency department logs, and other means to identify empanelled Airmen seen elsewhere to render appropriate aeromedical dispositions.

2.2.4.6.2. When Airmen are hospitalized under the care of a non-FS provider, the FS clinically monitors the Airman's care/progress and provides aeromedical consultation as necessary.

2.2.4.6.3. FSs serve as liaison between flying and SOD personnel/units, and available medical services.

2.2.4.7. FSs ensure medical, dental, and support staff are aware of aviation and operational medicine requirements.

2.2.4.8. FSs consult with health care specialists to deliver optimal clinical care and expedite aeromedical dispositions.

2.2.4.9. FSs provide advice relevant to unique elements of aeromedical exposures that might influence consultants' diagnosis and treatment.

2.2.4.10. FSs consult with SGP on complex aeromedical disposition cases. FSs will contact MAJCOM/SGP(A) before talking to AFMSA/SG3PA, and/or the Aeromedical Consult Service (ACS) who are also available for consultation.

2.2.5. **Qualification Physicals**

2.2.5.1. FOMC performs professional and paraprofessional portions of initial Flying Class I (when indicated), IA, II, III, and other SOD physicals including initial commissioning physicals IAW AFI 48-123.

2.2.5.2. Optometry personnel accomplish eye examinations supporting flight/SOD physical examinations IAW AFI 48-123 or higher headquarters direction (*e.g*. waivers and ACS).

2.2.5.3. FSs certified as FAA Aeromedical Examiner complete FAA Class 2, Class 3 medical examinations supporting mission requirements. Examinations may be completed on a space available basis when not mission essential. (Not applicable to AFRC. FAA examinations will not be accomplished by Reserve physicians in military status).

2.2.5.4. FSs assess flight medical clearance for incentive and orientation flights or jumps IAW AFI 48-123.

2.2.5.5. Inter-service FSs may fly with appropriate AF units IAW AFI 11-401, *Aviation Management* paragraph. 1.10..

2.2.6. **Aircrew chemoprophylaxis ground testing**

2.2.6.1. Rated and career enlisted aircrew will be ground tested with operationally required prophylactic medications (i.e. Ciprofloxacin) per the Official Air Force Aerospace Medicine Approved Medications list under supervision of a FS prior to completing initial aircrew training or as mission requires. Select eligible aircrew/special duty personnel may also be offered voluntary ground testing for No-Go medications: temazepam, zolpidem, and zaleplon. Current dosages for ground testing are located in the Official Air Force Aerospace Medicine Approved Medications list located on the AFMS Kx. Ground test results (or deferrals) are documented on DD Form 2766, *Adult Preventive and Chronic Care Flow Sheet,* and in the medical record for these medications.

2.2.6.2. The FS at base-level ensures that eligible personnel authorized to use Go-Pills are offered voluntary ground testing for dextroamphetamine and/or modafanil. Current dosages for ground testing are located in the Official Air Force Aerospace Medicine Approved Medications list located on the AFMS Kx under Flight Medicine/Standards. Documentation of testing or deferral is placed on the DD Form 2766 and in the medical record.

2.2.7. **Medical evaluation and disposition following suspected ocular directed energy exposure.** ***Note****: Exposures to known directed energy sources previously deemed eye-safe by either AF or other competent United States (US) governmental authorities are exempt from these follow-up requirements.*

2.2.7.1. Individuals with suspected ocular directed energy exposure are evaluated by an eye specialist (ophthalmologist or optometrist) if available, or by a FS as soon as possible and again 24-hours post event. Contact base BEE as the Base Laser Safety Office to begin an investigation if not already started.

2.2.7.2. For normal results in asymptomatic patients, individuals may be returned to unrestricted duty including flying.

2.2.7.3. Aircrew with persistent visual complaints or symptoms without objective findings will be placed in Duties Not Involving Flying (DNIF) status and referred to eye specialist. Non-aircrew with persistent visual complaints or symptoms without objective findings will also be referred to eye specialist. Specific duty restrictions may be warranted based on personal and operational safety concerns.

2.2.7.4. Suspected ocular directed energy exposures must be reported to DoD Tri-Service Laser Injury Hotline; (800)-473-3549; (937) 938-3764; or DSN 798-3764.

2.2.7.5. Confirmed ocular directed energy exposures must be reported as at least a Class E Physiologic event, or if appropriate, at a higher class level IAW AFI 91-204, *Safety Investigations and Reports*.

2.2.7.6. Evaluation and treatment of contract personnel with ocular directed energy exposure is authorized for medically emergent cases.

2.2.7.7. All reporting procedure information for actual or suspected laser incidents can be found at the DoD Tri-service Laser Injury Hotline website or the "Laser Injury Guidebook" located on the AFMS Kx

(**https://kx.afms.mil/kxweb/dotmil/file/web/ctb_026112.pdf**) and provides information for managing ocular directed energy exposure.

2.2.8. **Contact Lens Program**. FOMC and optometry personnel manage the contact lens program IAW AFI 48-123.

2.2.9. **Eye Protection**. FOMC and optometry personnel manage the ballistic eye protection program and Laser Eye Protection (LEP) program for aircrew and special duty personnel. Refer non-aircrew / special duty laser users to base BEE for LEP. Guidance is located on the ESOH Service Center Homepage: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=CTB_124036&functionalArea=ESOH**. FOMC and optometry personnel perform examinations and certify approval for aircrew use of high contrast visors.

2.2.10. **Aeromedical Evacuation (AE)**

2.2.10.1. FSs coordinate with theater surgeons and AE personnel in clinical aspects of peacetime and operational AE. SGPs are the local facility consultants for AE. FSs provide professional oversight of AE patients leaving, arriving or remaining overnight at facilities ensuring patients receive optimal medical care before, during and after AE missions.

2.2.10.2. FSs are the local clearance authority determining whether patients are clinically stable and physiologically ready for air transport. FSs will ensure proposed enroute treatment is appropriate and compatible with flight, IAW applicable guidance.

2.2.10.3. FSs work with referring physicians and Patient Movement Requirements Center to obtain validation of AE requests.

2.2.11. **Aeromedical Staging Facility (ASF).** FSs assigned to locations with ASFs coordinate aeromedical care and flying clearances with ASF personnel. FSs assess patients for combat stress and coordinate management of these patients in collaboration with Mental Health.

2.3. PRP/PSP Elements. ***NOTE****: A PRP element will be established to care for PRP certified members according to the current established AFMS manpower standard. Primary reference is* DoD 5210.42R_AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP) and AF Manpower Agency.* ***NOTE:*** *PSP (Presidential Support Program) personnel may also be empanelled in the FOMC/PRP Element, and are cared for with the same concerns and considerations as the PRP personnel. General references include DoDD 5210.55 15 Dec 1998.*

2.3.1. **Empanelment/Population Served**: members on PRP/PSP status excluding flying personnel.

2.3.2. **Staffing**: Stand-alone PRP Elements are staffed with physician assistants (42GX), nurses (46NX), and/or enlisted personnel (4N0X1, 4A0X1, Mental Health Service 4C0X1) per the current manpower standard.

2.3.2.1. PRP medical support staff should be assigned to the PRP stand-alone element or FOMC for a minimum period of 24 months to obtain the necessary proficiency. Rotations must be coordinated with the lead Competent Medical Authority (CMA), SQ/CC, and the respective functional manager. Premature rotations (based on the needs of the AFMS and local mission) must be approved by the MDG/CC.

2.3.2.2. PRP medical support staff will be designated with Special Experience Identifier (SEI) 463 IAW AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted).*

2.3.2.3. Supervisors/MTF(RMU) functional managers are responsible for ensuring documentation of SEI award in personnel records.

2.3.2.4. A CMA responsible for PRP duty dispositions must be available on call to provide PRP status disposition to members and the Certifying Official, IAW DoD 5210.42R_AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP).* This can be accomplished in person, or by electronic means (i.e. telephone/radio/e-mail).

2.3.2.5. The MTF(RMU) will ensure CMA contact information is provided to units with PRP personnel and to the Wing Command Post.

2.3.3. **Training**:

2.3.3.1. Assigned medical staff that directly supports PRP will accomplish AF Standardized PRP training IAW DoD 5210.42R_AFMAN 10-3902 . Additionally the Lead CMA will ensure all other medical personnel are trained to their appropriate level as contained within the MTF training slides.

2.3.3.2. Lead CMA, primary CMA (if designated), and lead MTF(RMU) PRP monitor will attend the one-time USAFSAM Medical PRP Course for certification within 6 months of duty supporting PRP.

2.3.4. **Services Provided**

2.3.4.1. PRP clinics provide primary medical and preventive care services to empanelled members. Clinical preventive care is IAW established policies and priorities outlined by Population Health Working Group.

2.3.4.2. PRP clinics provide medical care and consultation through clinical appointments and referrals. SGPs determine optimal appointment templates.

2.3.4.3. CMAs communicate to the Certifying Officials any recommend changes in PRP status of members on PRP according to approved guidance.

2.3.4.4. PRP/FMOC clinics process personnel requiring initial administrative PRP qualification. These personnel will remain enrolled in PRP/FOMC clinic until denied or dismissed, as PRP/FOMC provides continuous monitoring of these personnel. PRP reporting for these personnel is only necessary if the condition potentially disqualifies the Airman prior to starting PRP duties IAW DoD 5210.42R_AFMAN 10-3902 and AFI 10-203.

2.4. METALS supporting Flying and SOD Personnel Program. (Ref the Kx website at **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_034056.pdf**) The SGP, using the AF/SG3 approved METALS template located on the AFMS Kx, will develop a local prioritized list of METALS and an annual execution and monitoring plan which will be reviewed annually by the MAJCOM/SGP. This plan will ensure all FSs meet both clinical and non-clinical requirements to include METALS and squadron support activities, and carry the intent that approximately 50% of the FS's time is spent covering clinical workload and 50% accomplishing METALS and squadron operational support activities. Not all operational support activities exist or are of the

same importance at each base due to different mission requirements, thus should be reflected in the SGP's annual plan.

2.4.1. All FSs (MTF(RMU)-based and SME) conduct operational inspections of agencies whose mission is support of aircrew such as: life support, control tower, alert facilities, radar approach control (RAPCON), fire department, parachute units, flying squadron and space operations units. Frequency of visits is tailored to mission requirements. Each agency will be inspected at a minimum quarterly, (annually for ANG).

2.4.2. **Heads-Up Display (HUD) video review.** Qualified FSs and AOPT personnel conduct in-flight and HUD video review of anti-G straining maneuver (AGSM) IAW AFI 11-2 F-15/F-16/F-22/A-10 V1s and AFPAM 11-419. Representative sample size and frequency of HUD videos determined by the SGP will be reviewed and should include all assigned MDS that utilize HUD videos. SGPs pair personnel experienced in HUD video review with newly trained personnel ensuring adequate skill development in HUD video review and interpretation.

2.4.3. **Aeromedical briefings**. FS, AOPT and AOP brief aeromedical topics at wing safety meetings, instrument refresher course, night vision goggle training, operational resource management/crew resource management course, squadron commander's calls, pre/post deployment, and professional medical staff meetings. (**Note:** not an all-inclusive list)

2.4.4. **Fatigue countermeasures**. One of the FS's responsibilities is to prevent or limit fatigue in his/her operational population. The FS is encouraged to use modalities available to mitigate fatigue and sustain operations. (See section 6.2.2.13 regarding fatigue countermeasures program)

2.4.5. **FS flying**. FSs will fly all aerial missions supported at their base including tenant units where cockpit configuration allows a second crewmember, including remotely piloted aircraft (RPA) missions.

2.4.5.1. FSs participate in flight planning, briefing, and debriefing activities.

2.4.5.2. FSs assess, consult with AOPT and/or AOP, and report physiological and psychological stresses associated with flying missions, and provide flying commanders/supervisors advice concerning aeromedical issues related to aircraft, equipment, mission plans, and environmental stresses that affect mission completion, flying safety, or the health and morale of flying personnel.

2.4.6. **Medical Support for Installation Safety Program**

2.4.6.1. FSs establish and maintain close liaison with the installation safety office.

2.4.6.2. FSs must have access to AF Safety Automated System (AFSAS).

2.4.6.3. FSs provide support to safety investigations, to include reviewing medical records, consulting with specialists as required, and providing to the safety investigating officer a written summary and/or records of relevant medical information IAW AFI 91-204, para 2.3. and para 5.7.2.

2.4.6.4. FSs attend installation safety meetings and present operational medicine topics applicable to installation safety.

2.4.7. **Emergency Medical Response.** *Note*: S*ee chapter 7 for more details. Note: Sect. not applicable to AFRC*

2.4.7.1. FOMC develops policies ensuring FSs and FM technician(s) are on-call providing aeromedical support within a reasonable period defined by the SGP. Copies of on-call schedules are distributed to flight safety, command post, and emergency room or other after-hours POCs for the medical facility. *(not applicable to ANG)*

2.4.7.2. FSs establish procedures and directives for management of decompression sickness (DCS) attributable to flying, diving, or altitude chamber exposure.

2.4.7.3. FSs provide medical oversight and emergency response to physiological and/or medical incidents resulting from hypoxia (i.e. altitude chamber or Reduced Oxygen Breathing Device (ROBD)), and/or centrifuge training IAW chapter 7 of this Instruction as applicable. During all scheduled training events, a designated flight surgeon must be able to continuously respond by telephone and get to the training facility in the timeliest manner possible.

2.4.7.4. FSs conduct appropriate medical history and physical exam, and collect appropriate laboratory samples as part of ground or aviation mishap investigations IAW approved policies and utilizing chain of custody. The FS ensures no mishap investigation information is entered into the member's medical record.

2.4.8. **In-Flight Evaluations**

2.4.8.1. FSs perform in-flight evaluations and functions when indicated to evaluate/observe members in duty setting, e.g. cockpit, aircrew-seating position, RPA control positions, missile silos, etc.

2.4.8.2. FSs will be proficient in operation and instruction of night vision goggles (NVG) supporting aircrew and other operational users. (See section 6.3.1. for Air Force-wide NVG training requirements)

2.4.9. **Occupational Medicine (OM).** See Chapter 3 and refer to AFI 48-145, *Occupational and Environmental Health Program* for guidance.

2.5. SME Operations.

2.5.1. **Objectives**

2.5.1.1. The SMEs provide direct medical support both in garrison and when deployed to assigned squadron personnel to optimize health and performance.

2.5.2. **SME composition**

2.5.2.1. One FS, AFSC 48XX. Certified as medically qualified/acceptable for Flying Class II duties. FSs holding categorical waivers will be medically acceptable for their assigned MDS. Must be medically qualified for worldwide duty. FSs with an ALC should not occupy an SME billet.

2.5.2.2. Enlisted composition should be one IDMT(4N0X1C) and one 4N0X1 or two IDMTs depending on mission needs. If no IDMTs are available, MAJCOM/SG (or AFRC/SG) may waive the AFSC requirements and substitute a 4N0X1 for the IDMTs.

2.5.2.2.1. There should be one 7-level and one 5-level technician assigned. AFRC technicians should hold at least a 5-skill level to perform SME duties while deployed. MAJCOM/SG may waive this requirement.

2.5.2.2.2. Must be medically qualified for worldwide duty. Technicians with an ALC should not occupy an SME billet due to frequent deployment assignments.

2.5.3. **Performance Reporting**

2.5.3.1. Reporting official for the SME FS will be the flying squadron commander. SME FS's Officer Performance Reports (OPR) flow up operational review chain. If MTF(RMU) and line commanders concur, the rater can be the immediate MTF(RMU) supervisor. The OPR would return to the line chain for first and second level review/endorsement.

2.5.3.2. MTF(RMU) SGP will provide clinical performance input to flying squadron commander for evaluation of assigned SMEs.

2.5.3.3. The reporting official of enlisted SMEs will be the senior SME technician and/or SME FS. SME technician's Enlisted Performance Report (EPR) flows up operational chain for review/endorsement. MDG 4N0X1 functional manager reviews draft EPRs for administrative correctness and provide comments on content. EPRs reflect the technician's duty performance supporting the line unit, AME, and duties within the MTF(RMU).

2.5.4. **In-Garrison SME Operations.** *Note: AFRC/SME does not perform clinical care in garrison. Occupational examinations will occur in the RMU or MTF while in garrison.*

2.5.4.1. Clinical care delivered by SME personnel will occur in the MTF(RMU). (Exceptions may occur amongst some AFSOC units.)

2.5.4.2. SME personnel will be fully integrated with the MTF(RMU) and work under clinical supervision of the SGP. SGPs coordinate with line chain of command to assign and manage professional duties of SME personnel ensuring that approximately 50% of time is spent covering clinical workload and approximately 50% accomplishing METALS and squadron operational support activities.

2.5.4.3. SME FSs will maintain credentials with the MTF(RMU) and perform duties within the MTF(RMU) sufficient to warrant award and maintenance of clinical privileges.

2.5.4.4. SME personnel serve as an integral part of home station Aeromedical Team, performing the same FS and technician duties (e.g. on-call and emergency room coverage, records reviews, exercises) as non-SME FSs and enlisted personnel. Duties and responsibilities include those required to accomplish the Aerospace Medicine Enterprise as outlined in AFI 48-101 and the 4N0X1 CFETP. (Exceptions may include AFSOC and CSARME personnel)

2.5.4.5. Enlisted SME personnel will maintain required skills noted in CFETP.

2.5.4.6. SMEs with IDMT certification will meet rotational and medical skills maintenance training required for continued IDMT certification IAW AFI 44-103, *The*

Air Force Independent Duty Medical Technician Program, for the duration of assignment as a SME.

2.5.4.6.1. Failure from the IDMT course, and failure to maintain rotational and clinical training skills, are grounds for removal from or denial of occupying an SME position.

2.5.4.7. SME personnel are encouraged to participate in both flying squadron and MTF(RMU) activities such as commander's calls, social functions, etc. For administrative programs where it is not appropriate to do both, (e.g. awards programs, orderly room functions, intramural sports), SME personnel fall under the flying squadron.

2.5.4.8. SME personnel complete all waivers, MEBs, physicals and other routine exams for assigned unit personnel

2.5.5. **Deployed SME Operations**

2.5.5.1. SMEs may be the sole medical assets supporting a deployed location. SMEs are responsible for providing medical support to the entire PAR. SMEs implement appropriate aspects of the Aerospace Medicine Enterprise supporting mission and personnel.

2.5.5.2. SMEs tasked with other medical assets supporting a larger operation and PAR are responsible to medical leadership (deployed SGP, expeditionary medical squadron or group commander) to provide medical care and support the Aerospace Medicine Enterprise. SME FSs may be tasked to serve as Director, Base Medical Services (DBMS), or as core medical provider for large-scale exercises (e.g. Red Flag).

2.5.5.3. SMEs deployed to locations with a fixed MTF(RMU) must identify themselves to the MTF(RMU) commander or SGP. Clear lines of communication must be established and support requirements for SMEs identified. SMEs using fixed MTF(RMU) services (pharmacy, lab, or other services) may be required to submit a credentials transfer brief and complete other administrative procedures.

2.6. Meetings.

2.6.1. **FMWG**

2.6.1.1. FMWG should convene weekly but not less than monthly.

2.6.1.2. FMWG membership is SGP, all available FS, clinic nurse, NCOIC, MSME personnel, and other key FOMC personnel.

2.6.1.3. FMWG will:

2.6.1.3.1. Review and recommend action on cases recorded on AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty or Special Operational Duty Log.* AF Form 1041s are kept on file for five years then destroyed. Reference: Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/rims.cfm**

2.6.1.3.2. Review AIMWTS workflow data including new aircrew/SOD waivers, waiver renewals, and interim follow-up studies.

2.6.1.3.3. Review all open initial flying/SOD physical examinations.

2.6.1.3.4. Review/follow-up on all open referrals for flying/SOD personnel to local network, (both waiver & non-waiver related).

2.6.1.3.5. Review and track aeromedical data from other clinics, (i.e. dental, optometry, mental health and any others deemed necessary by the SGP).

2.6.1.3.6. Plan and schedule operational site visits (shop, food facility, life support, etc) to meet METALS operational requirements.

2.6.2. **DAWG**: See section 1.3.8.8 and reference AFI 10-203.

2.6.3. **OEHWG** as described in section 3.3.1.

2.6.4. **PHWG** as described in section 5.3.1.

2.7. Metrics: are IAW AFI 48-101, section 2.4.

Chapter 3

OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) OPERATIONS

3.1. Objectives and desired effects: OEH operations protect AF personnel (both AD and civilian employees) from inherent health hazards associated with AF industrial activities and the environment; comply with Federal, State and Local laws and requirements (including the Rehabilitation Act of 1983, 29 USC 794, and the Genetic Information Non-Discrimination Act, 42 USC 2000ff et seq.); and promote a healthy, fit work force to enhance performance of mission essential functions.

3.2. Organization and Functions: are IAW AFI 48-145. The Installation Occupational and Environmental Medicine Consultant (IOEMC) should be familiar with the content of this publication. *Note: For AFRC, 3.2.1.2, 3.2.1.3, 3.2.1.7, 3.2.1.10, 3.2.1.12, 3.2.1.13, 3.2.1.15, 3.2.1.16, 3.2.1.17, 3.2.2.1 through 3.2.2.7 are not applicable at either collocated or non-collocated bases. Note: ANG providers do not perform Occupational Exams for civilian employees. The exams performed would be for AD or traditional drill status guardsmen (DSG). This would also be true for paragraph 3.2.1.2, 3.2.1.3, 3.2.1.6, 3.2.1.7, 3.2.1.10, 3.2.1.16, 3.2.1.17, 3.2.2.3, 3.2.2.4, 3.2.2.5, and3.2.2.7.*

3.2.1. **OEH duties at bases with no designated OM services clinic include:**

3.2.1.1. Shop visits: All category I similar exposure groups (SEGs) require an annual FS visit. These visits are to detect potentially uncontrolled hazards and enable inspecting physicians to make accurate determinations of work relatedness (i.e. accurate determinations on AF Form 190, *Occupational Illness/Injury Report*). Physicians will perform shop visits as they deem necessary as part of a work related illness/injury investigation. Physician requirements for shop visits are IAW AFI 48-145.

3.2.1.2. Fitness for duty evaluation: Supervisors may request a medical assessment of a civilian employee's fitness to perform essential functions of their assigned job without endangering health and safety of the employee or others. Providers must read and understand the OASD/HA relevant sections of AFI 48-145 before performing these evaluations.

3.2.1.3. Pre-placement fitness exams (civilian): A subset of fitness for duty evaluations essential to placement of new civilian workers in positions with identified functional requirements and environmental demands. These are performed at the request of Civilian Personnel Services (CPS). CPS must provide detailed guidance on functional and written medical standards (e.g. firefighters).

3.2.1.4. Certification exams: Workers may require health care provider-endorsed certification exams with a periodic renewal requirement (e.g. Occupational Safety and Health Administration (OSHA) respirator exam). Military members required to carry MOPP gear, M-45 or M-50 CBRNE masks for WMD events are not required to be enrolled in the Respiratory Protection Program unless performing other duties using them. *Note: For AFRC: Certification examinations for other than military members is limited to those specifically identified by local agreements at each non-collocated base.*

3.2.1.5. Occupational and Environmental Health Working Group (OEHWG) management: IOEMC works with PH, Bioenvironmental Engineering (BE) and Safety representatives in this monthly meeting to identify adverse health trends, propose actions to the AMC, and determine the content of surveillance medical examinations for each SEG. *Note: <u>For AFRC</u>: The absence of Public Health Officers requires the use of contract assets at non-collocated bases. AFRC assets are not privileged or credentialed to provide care to civilians. Examinations and surveillance for other than military members is limited to those specifically identified by local agreements at each non-collocated base.*

3.2.1.6. Surveillance Program: IOEMC works with PH ensuring medical surveillance exams are available for AD and civilian workers belonging to SEGs for which the OEHWG has created an exam protocol. PH communicates with supervisors of SEG members ensuring currency of SEG rosters and compliance with surveillance medical exam requirements (The IOEMC may reassign this duty to meet local requirements). Employees/supervisors are notified to schedule required routine and overdue exams. The FOMC is also responsible for performing medical surveillance exams.

3.2.1.7. Injury/illness (determine causality, treat AD): Once PH has entered illness information into AFSAS and BE has reviewed it, IOEMC enters the determination of whether or not condition was caused by factors of employment. Injuries are typically reported to OSHA by Safety, but IOEMC may be asked to provide an opinion regarding an injury by the Installation Compensation Program Administrator (ICPA), CPS or the Judge Advocate General (JAG). AD Airmen with work related illnesses and injuries are treated by their assigned PCM. They may be referred to OM service clinics if available (e.g. Air Logistics Centers).

3.2.1.8. Hearing Conservation Program: FOMC directs and supports hearing conservation program administered by PH. FSs or occupational medicine physicians are responsible for evaluating patients with hearing threshold shifts, and disposition to either confirm and reset baseline audiogram or refer to audiology if indicated. See AFOSHSTD 48-20, *Occupational Noise and Hearing Conservation Program*, for guidance.

3.2.1.9. AF Form 190 in AFSAS (review authority): After PH has initiated the AF Form 190, the IOEMC reviews and completes it determining if the illness is work related.

3.2.1.10. Protecting Our Workers and Ensuring Reemployment (POWER) (Formerly Safety, Health and Return-to-Employment (SHARE)) Program: The local Civilian Personnel Services (CPS) appoints one of their own to be the liaison to the Injury Compensation Team (ICTL). The ICT is located centrally at AFPC/DPIRPC. The ICTL runs the POWER Working Group and administers the program. The IOEMC supports this program by reviewing medical records of individuals identified by ICT Liaison for consideration. The IOEMC provides medical guidance to include work limitations and durations required for each employee.

3.2.1.11. Fetal Protection: The IOEMC provides consultative support to PH for this program. For pregnant civilian industrial employees, The IOEMC writes a letter to their supervisor recommending work limitations to ensure protection of fetal health. (See AFI 44-102 for further guidance.)

3.2.1.12. The IOEMC is the medical consultant to PH for management of Medical Employee Health program. (See AFI 44-102 and AFI 44-108 for further guidance.)

3.2.1.13. Investigations/epidemiology/trend analysis: The IOEMC works closely with PH and BE and occasionally with Ground Safety to identify, investigate and recommend appropriate interventions for adverse trends involving occupational and environmental hazards. This takes place during OEHWG, but may be required any time an adverse trend is identified (e.g. a complaint, a shop visit adverse finding etc.).

3.2.1.14. Providers must be briefed on installation industrial health hazards annually. This can be accomplished during their Professional Staff meetings.

3.2.1.15. Risk communication. The IOEMC may be tasked to provide risk communication support during a perceived adverse health trend, environmental contamination, etc.

3.2.1.16. Office of Personnel Management disability retirement exams/reviews. CPS may request an AF physician review and provide opinions for civilian employee applications for disability retirement.

3.2.1.17. Consultation to management (meetings, classes, supervisors). Occupational Environmental Medicine (OEM) physician consultation enables supervisors to make appropriate administrative decisions regarding civilian employees with alleged medical issues that affect their work status (e.g. security clearance, safety, Equal Employment Opportunity (EEO) complaints, possible epidemics due to work place hazards etc.).

3.2.2. **OEH duties at bases with an OM services clinic**.

3.2.2.1. All duties listed in **3.2.1**. along with the following:

3.2.2.2. SGPs, in the absence of a credentialed Occupational Medicine Physician will be appointed the IOEMC/OEHWG chair by the MDG/CC. Alternate/substitute IOEMCs must be credentialed FS or occupational medicine physicians.

3.2.2.3. Civilian Employee work related injury & illness care. Care is limited to conditions the AF provider determines are most likely work related, and must not be for conditions exceeding scope of clinical care that can be provided in the AF MTF(RMU). Workers should be encouraged to complete the appropriate application for coverage through the appropriate compensation program.

3.2.2.4. Case management. Case management of civilian work related illnesses and injuries involves aggressive evaluation, treatment and return to work. This is separate and distinct from case management provided by MTF medical management function. Care is required to avoid conflict with Workers' Compensation Program case managers who have priority for these cases. Information from OEH case management activities is relevant to activities of the ICPA.

3.2.2.5. Disability Assessment (e.g. per American Medical Association (AMA) guidelines): When resources permit, a trained OEM provider may perform assessments of the percent disability using the currently accepted AMA guidelines to impairment and disability. These are done in support of a patient's application for an Office of Worker's Compensation Programs (OWCP) award for loss of function and can also be obtained in the civilian community through an independent medical examiner.

3.2.2.6. Consultation support to providers. AF OEM physicians provide consultative services to other AF health care providers, BE, Wing Safety, and PH.

3.2.2.7. Employee Assistance Program (EAP) liaison. Civilians seen in OEM clinic are occasionally referred to EAP for assistance. OEM providers should maintain a good working relationship with EAP personnel. EAP personnel are typically not credentialed by MTF(RMU)s and OEM providers must not provide clinical oversight of EAP activities.

3.2.2.8. Medical Review Officer (MRO) for Demand Reduction. The MRO is a licensed physician responsible for receiving and reviewing laboratory results generated by the alcohol and drug testing program. OEM physicians must obtain and maintain MRO certification through Medical Review Officer Certification Council (MROCC) in compliance with Title 49 CFR Part 40. Information gained from this certification process is key to proper management of employees with drug or alcohol problems. For OEM physicians serving as MRO, this certification authenticates their determinations made on active duty members.

3.2.2.9. Injury/Illness reporting using OSHA Form 301, *Injuries and Illness Incident Report* . AF physician completion of OSHA Form 301 (when required IAW OSHA) for both injuries and illnesses is required when the OEH physician has had clinical responsibilities.

3.3. Meetings:

3.3.1. **OEHWG**

3.3.1.1. OEHWG is the team responsible for Occupational and Environmental Health Program Activities and reports regularly to MTF leadership through the AMC. The IOEMC chairs the OEHWG and members include representatives from PH, BE, Ground Safety, Aerospace and Operational Physiology, and FS. Meetings are monthly. See AFI 48-145 for further guidance. *Note: for AFRC, the MSME rep will attend*

3.3.1.2. The IOEMC is final approval authority determining content of surveillance medical examination protocols for each SEG.

3.3.2. **Installation Environment, Safety and Occupational Health Council (ESOHC)**

3.3.2.1. At AF installations, the Wing /CC is the chair of the ESOHC.

3.3.2.2. The SGP or IOEMC, along with BE and PH should attend this meeting to provide the Wing, Group and Squadron commanders awareness of relevant base-wide OEH issues and serve as subject matter experts.

3.3.2.3. The SGP or IOEMC ensures regular reports are provided to the installation ESOHC on base and organizational compliance with Medical Surveillance Examinations.

3.4. Metrics: are IAW AFI 48-101, section 3.4.

Chapter 4

MEDICAL FORCE PROTECTION PROGRAM (MFPP)

4.1. Objectives and desired effects: The MFPP purpose is for protection and promotion of Airmen's health in garrison and when deployed. Integral to the MFPP is accurate identification and characterization of duty limiting conditions, medical clearances, and medical engagement throughout deployment process.

4.2. Organization and Functions.

4.2.1. The FOMC is responsible for MFPP activities and reports to the MTF(RMU) leadership through the AMC IAW AFI 10-203.

4.2.2. The FOMC provides Airmen on flying/SOD status medical support for deployments.

4.2.3. Deployment support includes: line medical support, medical briefs, planning/logistics, medical threat research/analysis/briefings, pre and post medical screening/clearances, site survey and consultation to other MTF(RMU) PCM teams on deployment issues.

4.2.4. PHAs and Flight Physical Exams: Flying and SOD personnel will follow existing guidance in AFI 44-170, *Preventive Health Assessment.* Required examinations for personnel requiring AF Form 1042 should be in sync with current PHA and IMR reporting business rules. The local SGP will determine whether these PHAs are best managed in the FOMC or PHA Cell.

4.3. Medical Standards Management Element (MSME). This is the central functional element of the MFPP and is staffed primarily by the 4E0X1s in the active duty FOMC (with 4N0X1 as alternate), by the Senior Air Reserve Technician (SrART) in the physical examination section for AFRC, and Senior Health Technicians for ANG. The intent is a centralized medical standards review and management section. The ideal location for the MSME is in the FOMC (but is individually MTF(RMU)-specific dependent upon space). The MSME manager/lead (SrART) appointed by the SGP should be the most senior and knowledgeable civilian/contract/enlisted 4E0X1, and shall report to the Flight Medicine/CC or directly to the SGP depending upon the size of the MDG

4.3.1. **Profile Management.** The MSME is the initial point of contact for all profiling actions, is responsible for the profile-related administrative tasks, manages these profiles/DLCs IAW AFI 10-203 and AFI 48-123, and serves as the communications link between squadron/unit commanders, supervisors, and the health care providers.

4.3.1.1. Profile officers are appointed in writing by the MTF(RMU)/CC and should normally be flight surgeons credentialed and working in flight medicine. The MAJCOM/SGP may authorize deviations when no flight medicine clinic exists or no flight surgeons are available for appointment by the MTF(RMU)/CC.

4.3.1.2. The Profile Officer, IAW AFI 10-203, performs final validation and signs all AF Forms 422 regarding any of the following: Medical Disqualification from an AFSC; Retraining; direct entry from active duty into any AF Commission Programs (i.e. Officer Training School (OTS); AF ROTC or Airman Education Commissioning Program).

4.3.1.3. The standards experts in the AFMS are graduates of the Residency in Aerospace Medicine (RAM). Where a RAM is assigned and subsequently appointed by letter from the MTF(RMU)/CC, he/she should serve as the primary or senior profile officer when more than one profile officer is appointed by the MTF(RMU)/CC. At MTF(RMU)s where a RAM is not assigned, or the sole RAM is a squadron or group commander, the MTF(RMU)/CC may appoint the physician most knowledgeable in physical standards as the senior profile officer.

4.3.1.4. The Senior Profile Officer (SPO) is accountable to and appointed in writing from the MTF(RMU) Commander.

4.3.1.5. The SPO is responsible for oversight of all MTF(RMU) profiling actions as well as resolving conflicts between line commanders, other profile officers, and/or other providers. Note: See AFI 10-203 for further details.

4.3.2. **AIMWTS Management**

4.3.2.1. The MSME monitors AIMWTS and ensures waivers for flying/SOD personnel are scheduled allowing sufficient waiver processing time, and forwards through MAJCOM for disposition.

4.3.2.2. The MSME performs monthly AIMWTS workflow review. Expired/expiring waivers, interim evaluations pending, and open aeromedical summaries (AMS) must be reviewed.

4.3.2.3. Airmen whose waivers have expired or are expiring during the report month must be contacted and scheduled expediting waiver processing.

4.3.2.4. Delays in waiver processing beyond the Airman's control must have waiver expiration extension requested through MAJCOM/SGP.

4.3.2.5. Interim evaluations pending within 90 days must be scheduled ensuring timely waiver processing.

4.3.2.6. Open AMSs must be reviewed weekly during the FMWG ensuring timely processing. *Note: <u>For AFRC</u>: The open AMSs will be reviewed weekly by the SrART and reviewed monthly at AMC. Every effort should be made to resolve weekly. Note: <u>For ANG</u>: Open AMSs will be reviewed weekly by the MSME manager/lead and monthly by the SGP.*

4.3.2.7. The MSME ensures Airmen scheduled for ACS evaluation are notified and briefed on evaluation requirements.

4.3.2.8. The MSME ensures addendum requests sent are acted upon and returned in a timely manner.

4.3.2.9. The MSME will ensure Airman are notified of waiver dispositions, and AF Form 1042s are processed appropriately when examinations are returned from waiver authority. ***Note:*** *SSNs are being phased out as ID numbers. Use CAC ID number for Joint 1042-equivilent form.*

4.3.3. **Record Review** IAW AFI 44-170, Force Health Management (FHM), (or MSME for ANG), will ensure currency of all PHA, IMR, occupational health, and deployment health assessment requirements for both in and out-processing individuals. The MSME conducts all

medical standards reviews to include separation and retirement reviews. PRP reviews will be conducted IAW Chapter 2.3 of this AFI.

4.3.3.1. In-bound PCS Record Review. After initial medical record review by Force Health Management (including hard copy records and AHLTA per AFI 44-170), the MSME will review identified records of personnel with medical conditions that limit duty performance or deployment capability. Duty/mobility limitations suspected to be inappropriate, no longer necessary, or in need of correction or amendment are identified. The MSME forwards discovered information to PCMs (ANG medical providers) for evaluation and action. Questionable limitations will be made available to a profile officer to determine, in consultation with the Airman's commander and SPO or SGP, acceptable duty restrictions. *Note: For AFRC: The MSME function will forward the case to the DAWG for review of questionable duty or mobility restrictions.*

4.3.3.2. During this record review process, the (Physical Examination Board Liaison Officer (PEBLO), (*MSME or DAWG for AFRC),* will be notified of newly arrived Airmen who have ALCs to facilitate tracking of RILO requirements. In addition, Squadron/CC and their unit FSs are alerted to all waivers with interim follow-up requirements. Note: ANG members do not PCS, but can transfer into a unit from another ANG unit, active duty AF, or another active or reserve component. "Members with ALCs should be reviewed and approved by National Guard Bureau (NGB)/SGPF prior to transfer into an ANG unit.

4.3.3.3. Out-bound PCS Record Review. At out-processing, FHM refers members with overseas or remote PCS to MSME for additional medical clearance. (see **paragraph 4.3.4.6**)

4.3.4. **Clearances**

4.3.4.1. Special Duty Clearance. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review ensuring no potentially disqualifying information is noted and Airman is medically qualified to perform special duty. Once review is complete and Airman deemed qualified, the MSME creates an AF Form 422 which notes the special duty being performed, Airman's PULHESX, and specific verbiage pertaining to the special duty. The MSME will obtain appropriate signatures on the AF Form 422.

4.3.4.2. Reserve/Guard Duty Clearance. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review for Airmen wishing to transition from AD AF to AFRC or ANG duty. The MSME reviews records IAW AFI 48-123 Chapter 5, *Continued Military Service (Retention Standards)* ensuring retention standards are met. The MSME creates an AF Form 422 with PULHESX and a statement noting Airman is/is not medically qualified for reserve/guard duty, and then will obtain appropriate signatures on the AF Form 422. *Note: In applying these standards, the MSME will be cognizant of the fact that AFRC does not have the medical capability to absorb most ALCs or duty limited individuals, as nearly all UTC's are deployable.*

4.3.4.3. Retraining Clearances. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review ensuring no disqualifying information is noted. The MSME reviews records IAW the *Air Force Enlisted*

Classification Directory (AFECD) or the *Air Force Officer Classification Directory* (AFOCD) guidelines, located on the Air Force Personnel Center (AFPC) website, for intended AFSC(s). The MSME creates an AF Form 422 with PULHESX and indicates each selected AFSCs the Airman is/is not medically qualified to enter. The MSME will obtain appropriate signatures on AF Form 422.

4.3.4.4. Commissioning Clearances. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review ensuring no disqualifying information is noted. When commissioning clearance is completed, the MSME creates an AF Form 422 with PULHESX and a statement that the Airman is/is not medically qualified for the specific commissioning program. The MSME will obtain appropriate signatures on AF Form 422.

4.3.4.5. Security Clearances. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review for Airmen requiring security clearances, ensuring no disqualifying information is noted. If disqualifying information is found, the MSME ensures Airman are appropriately evaluated and cleared by his/her PCM or respective clinic. When the evaluation is complete, the MSME forwards all information and paperwork to the base Director of Medical Services (DMS) or delegated authority (i.e. PCM) for review and signature.

4.3.4.6. Overseas Clearances. Following PIMR(ASIMS) review by FHM, the MSME will accomplish medical record and AHLTA review ensuring no disqualifying information is noted. Individuals identified with a medical condition that may limit duty performance or deployment capability are managed IAW AFI 48-123 and AFI 10-203. Use specific administrative tools (checklists, algorithm and AIM templates) located in the MSME Toolkit on the Knowledge Exchange web site for all overseas clearances.

4.3.5. **Initial Flying/SOD Exam Management**

4.3.5.1. The MSME is the preliminary point of service for initial flying/SOD exam requests and ensures physicals are accomplished IAW AFI 48-123.

4.3.5.2. Reviews medical records, PIMR(ASIMS), and AHLTA ensuring disqualifying information is identified IAW AFI 48-123 Chapter 6, *Flying and Special Operational Duty*.

4.3.5.3. Ensures completion of DD Form 2807-1, *Report of Medical History* and DD Form 2808, *Report of Medical Examination.*

4.3.5.4. Orders required lab/diagnostic studies and schedules pre-examinations (e.g. Optometry and Dental).

4.3.5.5. Schedules a physical examination appointment with a FS after completion of above items 4.3.5.3. & 4.3.5.4. Ensures the 4N0X1 completes the paraprofessional portion as defined by their CFEPT and the FS completes the examination portion of DD Form 2808.

4.3.5.6. Enters initial DD Form 2807-1 and DD Form 2808 demographic information into the Physical Examination Processing Program (PEPP), conducts final data field review for completeness, and ensures signatures are obtained and forwarded to

appropriate Certifying Authority. Airmen with disqualifying conditions complete this process so approval/disqualification is accomplished at HQ/AETC/SGPS.

4.3.5.7. Ensures Airmen with potentially waive-able disqualifying conditions have waiver requests submitted through AIMWTS.

4.3.5.8. Monitors the initial physical examination process monthly ensuring compliance with established timelines IAW AFI 48-123, paragraph 2.4.1.

4.3.5.9. Reviews PEPP workflow ensuring physical status pending (PSP) requests are acted upon and returned to requestor in a timely manner.

4.3.5.10. Creates AF Form 422 noting PULHESX, and AF Form 1042 for physicals approved by Certifying Authority. Obtains appropriate signatures and issues the completed form to the Airman. *Note: SSNs are being phased out as ID numbers. Use CAC ID number for Joint 1042-equivilent form.*

4.3.5.11. The MSME is responsible for administrative oversight of the PEPP and performs quality reviews of documents prior to forwarding to the appropriate Certifying Authority.

4.4. Metrics: are IAW AFI 48-101, section 4.4.

Chapter 5

COMMUNITY HEALTH OPERATIONS PROGRAM (CHOP)

5.1. Objectives and Desired Effects: The CHOP promotes community health in garrison and while deployed. Integral to CHOP effectiveness is teamwork and communication between PH, BE, Health and Wellness Center (HAWC), primary care clinics, FOMC, and specialty care clinics.

5.2. Organization and Functions: The FOMC and PH teams are the teams primarily responsible for CHOP activities and report regularly to MTF(RMU) leadership through AMC *Note: For AFRC in garrison, CHOP functions are limited to travel and preventive services for military only in conjunction with deployment or mobilization. Food Safety program is in full effect at stand alone bases. Note: ANG Wings do not have HAWCs and ANG MDGs do not primary care, FOMC or specialty clinics.*

5.2.1. The AME employs effective risk communication ensuring installation's population and commanders are aware of force health protection risks and recommended mitigation strategies.

5.2.2. If the SGP is not the Preventive Medicine Clinical Consultant (PMCC), the MTF(RMU)/CC will appoint a FS as MTF(RMU) PMCC for communicable disease prevention and control measures (i.e. TB, sexually transmitted infection (STI), etc). These programs are administratively supported by PH and may be clinically executed by all PCM teams, but primarily the FOMC. Unless otherwise directed in Department of Defense Instructions (DoDIs) or AFIs, follow methods for controlling and preventing disease described in the Centers for Disease Control and Prevention (CDC) publication, *Morbidity and Mortality Weekly Report* (MMWR), and supplements. CHOP activities are regulated IAW: AFJI 48-110, *Immunizations and Chemoprophylaxis*; AFI 48-117, *Public Facility Sanitation;* AFI 48-116, *Food Safety Program*; AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance* which outlines, communicable disease surveillance/prevention/control, STI surveillance/prevention/control, latent tuberculosis infection (LTBI) management, and the Animal Bite Program; and AFI 48-135, *Human Immunodeficiency Virus (HIV) Program* which guides the AF HIV program. CHOP manages protected health information as confidential IAW HIPAA regulations. *Note: For ARC: Referral to Active Duty or civilian provider as indicated by duty status and location*

5.2.3. **Travel Medicine**

5.2.3.1. Preventive travel medicine services may be provided to eligible enrollees by any PCM team but primarily through the FOMC and PH. *Note: ARC has no travel medicine program. The FOMC/MSME (ARC equivalent) will be involved in pre and post-deployment chemoprophylaxis.*

5.2.3.2. PH is the initial point of service for travel medicine support of official travel. PH will obtain patient travel history including all locations, (i.e. stopovers and side excursions), time of year traveling and duration of each. PH provides the traveler with information on preventing minor illnesses (e.g. travelers' diarrhea), injuries and adverse environmental and vector-borne exposures.

5.2.3.3. PCMs/FSs review pre-travel history, patient's current medications, allergies, vaccinations and past medical history. Prescribes appropriate travel medications and recommends area specific prophylaxis and immunizations (e.g. anti-malaria, typhoid fever, yellow fever, etc) based on travel location and medical threats at time of travel.

5.2.3.4. Immunizations clinic provides travelers with routine immunizations such as tetanus, influenza and area specific vaccinations based upon recommendations from PCM/FS.

5.2.4. **Food Safety Program**

5.2.4.1. PH coordinates the Food Safety Program IAW AFI 48-116 *Food Safety Program,* and AFI48-117 *Public Facility Sanitation Program*. *Note: For AFRC, N/A while in garrison, except at stand-alone bases.*

5.2.4.2. PH submits the annual food facility trend analysis report, annual food facility evaluation frequency list and the public facility sanitation report for AMC review and approval. (Not applicable for collocated ANG bases)

5.2.4.3. FSs accompany PH on at least one food and public facility evaluation per quarter, (annually for ANG).

5.2.4.4. PH conducts food/water-borne outbreak investigations with PMCC unless there is a suspected/declared public health emergency, then coordination is with Public Health Emergency Officer (PHEO), (or NGB/SGPF for non-collocated ANG bases).

5.2.4.5. BE provides data and technical support during a water-borne outbreak investigation IAW AFI 48-144, *Drinking Water Surveillance Program*.

5.2.4.6. The PMCC approves final outbreak investigation report and submits it to the AMC for review. Additional reporting is IAW established policy.

5.2.5. **Communicable Disease Surveillance, Prevention and Control**

5.2.5.1. PH conducts local communicable disease surveillance, trend analysis, detection, case/contact interviews, epidemiological investigation and reporting IAW CDC, DoD, AF, and applicable state/local/host nation requirements. *Note: For AFRC, N/A while in garrison except at stand-alone bases.* *Note: ANG service members diagnosed with communicable diseases or STIs are referred to Active Duty (LOD) or to their civilian PCM/State Health Department as appropriate.*

5.2.5.2. PH coordinates with PMCC to provide recommended communicable disease prevention and control measures.

5.2.5.3. PH disseminates communicable disease surveillance information regarding the incidence/prevalence of diseases and conditions of interest/importance to health care providers and appropriate MTF(RMU) committees. (e.g. Population Health, Infection Control, etc.)

5.2.5.4. The PMCC reviews communicable disease trend analysis and outbreak reports. PMCC assists in development of clinical practice guidelines and provides recurring preventive medicine training to MTF(RMU) health care providers.

5.2.6. **STI Surveillance, Prevention and Control**

5.2.6.1. PH actively seeks, investigates and reports STI diagnosed patients and their associated contacts IAW CDC, DoD, AF, and applicable state/local/host nation requirements. *Note: N/A for AFRC in garrison. Note: ANG service members diagnosed with communicable diseases or STIs are referred to Active Duty (LOD) or to their civilian PCM/State Health Department as appropriate.*

5.2.6.2. PH provides STI prevention information and briefings to the installation's members as required and deemed appropriate.

5.2.6.3. PH coordinates with the PMCC to submit annual installation STI trend analysis report to the AMC.

5.2.7. **HIV Management**

5.2.7.1. PH coordinates with the designated MTF(RMU) HIV provider to manage base-level responsibilities of the AF HIV program IAW AFI 48-135.

5.2.8. **LTBI**

5.2.8.1. PH is the initial point of service for eligible beneficiaries with a positive TB skin test (TST) or Interferon-Gamma Release Assay (IGRA), IAW CDC, DoD, AF, and applicable state/local/host nation requirements. *Note: For AFRC, FHM/SrART or designee delegated in writing is the initial point of service for eligible reservists. Note: ANG service members with positive TB screening are referred to Active Duty (LOD) or to their civilian PCM/State Health Department as appropriate.*

5.2.8.2. PH conducts initial reactive TB screening case interviews and education.

5.2.8.3. PH seeks and investigates family members and/or close household contacts for current TB screening and medical evaluation. (n/a for ANG)

5.2.8.4. The PCM/FS evaluates eligible beneficiaries with reactive TST/positive IGRA to rule out active TB and suitability for antibiotic therapy. (n/a for ANG)

5.2.8.5. Health care providers consult the PMCC for current LTBI prophylaxis recommendations/guidelines. (n/a for ANG)

5.2.8.6. The FOMC ensures that assigned personnel on flying status be treated (ANG: referred for treatment), and undergo ground testing of their medication IAW the USAF Approved Aircrew Medications guidelines. When active TB has been ruled out, prophylactic therapy can be delayed for mission critical aircrew (e.g. combat zone or alert force) IAW AFI 48-105.

5.2.8.7. The PMCC reviews patient's AF Form 2453, *Tuberculosis Detection and Control Data* for appropriate clinical standard of care at completion/termination of treatment. (n/a for ANG)

5.2.8.8. PH coordinates with the PMCC to submit annual installation TB Risk Assessment report to the AMC. (n/a for ANG)

5.2.8.9. PH coordinates with the PMCC to provide recommended risk-based TB prevention and control measures for the installation's members as deemed necessary. (n/a for ANG)

5.2.9. **Animal Bite Program**

5.2.9.1. Eligible beneficiaries with animal bite exposure are evaluated and treated including initiation of DD Form 2341, *Report of Animal Bite-Potential Rabies Exposure. Note: ARC service members who sustain an animal bite are referred to Active Duty (LOD) or to their civilian PCM/State Health Department as applicable.*

5.2.9.2. Heath care providers may consult PH for local rabies prevalence and the PMCC for the most current rabies prophylaxis recommendations/guidelines.

5.2.9.3. The PMCC reviews the patient's DD Form 2341 for appropriate clinical standard of care upon completion, and annotates the comments section of "Final Disposition of Care", signing the "Medical Officer Review" block.

5.3. Meetings.

5.3.1. **Population Health Working Group (PHWG)** (n/a for ARC)

5.3.1.1. Cross-functional, multi-disciplinary group develops, validates, recommends and advocates strategies optimizing the health of the installation's population.

5.3.1.2. SGP attends PHWG.

5.3.1.3. PH attends as the epidemiology consultant, helps formulate questions regarding population health and provides data analysis.

5.3.1.4. Health Promotion attends as the subject expert and is the responsible agent for community-based prevention efforts.

5.3.1.5. BE attends as the subject expert for occupational and environmental health issues impacting personnel.

5.4. Metrics: are IAW AFI 48-101, section 5.4.

Chapter 6

HUMAN PERFORMANCE OPERATIONS

6.1. Objectives and Desired Effects: Human performance operations employ scientifically sound principles of preventive medicine and health promotion to sustain, optimize, and/or enhance the physical, psychological and social health and performance of Airmen in order to enhance and prolong a healthy quality of life and increase effectiveness. Teamwork and collaboration between flight medicine, AOPT, AOP, functional experts, and line leadership is vital to successfully addressing wing human performance issues. References include AFI 48-101 ch.6, AFI 11-403, *Aerospace Physiological Training Program* section. 1.7, and AFTTP 3-24.4.

6.2. Organization and Functions.

6.2.1. AME members are involved with sustaining, optimizing, and/or enhancing human performance. FSs, AOPs and AOPT personnel are the primary focal points. *Note: <u>For AFRC</u>, there is no Aerospace Physiologist. AFRC FS should make every attempt to consult with Active Duty AOPT for the purposes of this chapter.*

6.2.2. FSs, AOPs & AOPT personnel maintain operational flying duties and aircrew ground training currencies.

6.2.3. Assist SGP, line commanders, and supervisors in human factors analysis, assessment, and investigation.

6.2.4. The FS and/or AOPT reports aviation, ground, industrial, weapons and space mishap trends to SGPs at the AMC.

6.2.5. FSs & AOPT personnel conduct familiarization visits to operational facilities (e.g., RAPCON, control tower, parachute units, space operations facilities, etc.) and "shadow" operational activities to understand mission-related human factors and performance issues.

6.2.6. Members of Team Aerospace identify hazards and risks to human performance, and develop and implement training and material solutions enhancing readiness and combat capability.

6.3. Education & Training: SGPs ensure FSs, AOPs and AOPT personnel, when assigned, are engaged in Flying/SOD personnel squadron briefings, visits and activities (commander's call, squadron senior staff meetings, pre-deployment medical intelligence briefings, etc.) on a frequent basis ensuring competency and proficiency. Aircrew Training programs IAW AFIs 11-403 and 11-404 directly support Human Performance Operations, and should be reviewed to ensure compliance from the Aerospace Medicine Team.

6.3.1. **Night Vision Devices (NVD) Program Support**

6.3.1.1. AFI 11-202V1, *Aircrew Training,* defines AF-wide training requirements for use of NVDs. Aerospace Operational Physiologists will, (and when appropriate, FS or AOP technicians may), become certified NVD instructors as part of the training team and assist in initial and refresher training. Weapons specific training and operational requirements are IAW applicable AFI 11-2 series.

6.3.1.2. Flight Medicine screens records of Airmen who use NVDs and periodically confirm vision requirements are met IAW AFI 48-123 paragraph. 6.48.7, *Duty Requiring the Use of Night Vision Devices (NVD).*

6.3.1.3. The FS and/or AOPT must be knowledgeable on basic visual issues: e.g. contrast, ambient lighting, color vision, etc. and work with local aircrew flight equipment technicians and aircrew on LASER eye protection, high contrast visor, ballistic eye protection, and aircrew spectacle equipment optimizing performance of war fighters.

6.3.2. **Crew/Cockpit Resource Management (CRM) & Maintenance Resource Management (MRM)**

6.3.2.1. The AOPT supports the CRM program IAW AFI 11-290, *Cockpit/Crew Resource Management Training Program*.

6.3.2.2. The AOPT supports the MRM program IAW AFI 21-101, *Aircraft and Equipment Maintenance Management*, improving communication, effectiveness and safety in maintenance operations.

6.3.3. **Airsickness Prevention**

6.3.3.1. The SGP ensures flight medicine, AOPs and the AOPT provide a viable Airsickness Management Program. This program has demonstrated effectiveness in assisting officer and enlisted aircrew overcome airsickness, particularly students and experienced aircrew transitioning to new weapon systems. AETCI 48-102, *Medical Management of Undergraduate Flying Training Students*, provides an excellent foundation for local programs. Airsickness training will be annotated in the member's medical record.

6.3.3.2. Airmen should continue primary training/regular flight duties while participating in the Airsickness Management Program.

6.3.3.3. Aircrew able to continue to perform in-flight duties effectively with either active or passive airsickness without the need for aircrew support or medical intervention, should still be entered into local psychological and physiological adaptation training (i.e. Barany chair). (n/a to ANG)

6.3.4. **G-Awareness Continuation Training**

6.3.4.1. Involvement of FSs and AOPT personnel is integral to the success of the wing and squadron's G-awareness programs. Team members must have adequate training (to include centrifuge qualification IAW AFI 11-404, *Centrifuge Training for High-G Aircrew*) and be familiar with volume 3 G-awareness continuation training requirements outlined in the respective AFI 11-2-MDS. AFI 11-404 describes the initial qualification, and refresher centrifuge training requirements, and guidance and procedures for the handling aircrew that do not satisfactorily complete this training program.

6.3.5. **Thermal Stress**

6.3.5.1. AME personnel should maximize opportunities to educate and train Wing personnel on mission-specific hazards and risks of extreme thermal environments. Commander's calls, safety meetings, and shift changes are examples of potential venues.

6.3.5.2. Army Technical Bulletins MED 507: *Heat Stress Control and Heat Casualty Management* and MED 508: *Prevention and Management of Cold-Weather Injuries and TB MED* are excellent resources to support education and training activities.

6.3.6. **Nutrition**

6.3.6.1. FSs, AOPT, and HAWC personnel educate and train Wing personnel on the effects nutrition (including dietary supplements) have on mission-related performance and safety.

6.3.6.2. AME personnel ensure information contained in education and training materials are scientifically sound and relevant to the mission.

6.4. Fatigue Countermeasures Program.

6.4.1. A primary aim for the FS, AOP and AOPT is sleep hygiene, education and mitigation of effects of fatigue on successful mission completion. This is accomplished through advocacy, consultation with leadership, evaluation/analysis of threats, education, training, and use of approved fatigue countermeasure tools. FSs, AOPs and AOPT personnel must be knowledgeable on AF guidance pertinent to mission and warfighters being supported. A mandatory starting point for supporting fatigue management in flying operations is AFI 11-202V3, *General Flight Rules*, chapter 9 *Crew Rest, Fatigue Management and Flight Duty Limitations*. In addition, several platforms have guidance in volume 3 of their respective AFI 11-2-MDS. The publication, *Warfighter Endurance Management During Continuous Flight and Ground Operations*: *An Air Force Counter-Fatigue Guide*, is an excellent resource on fatigue management and can be found on the AFMS Kx: **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_140581.pdf**.

6.4.2. The FS, AOP and AOPT train leadership, aircrew, operators, supervisors, and schedulers on the full spectrum of fatigue prevention and operational fatigue countermeasures. SGPs advise wing leadership of fatigue countermeasures strategies.

6.4.3. AME personnel identify fatigue issues during shop visits and report findings to the AMC to develop mitigating strategies and/or training. AOP, AOPT and SMEs collaborate in developing counter-fatigue strategies for their units.

6.4.4. The FSs, AOPs and the AOPT evaluate fatigue management strategies for long duration flights including RPA operators, night operations and high ops tempo sorties. The FS and AOPT participate in unit mission planning indicated by unique airframe, AFI or requested by flying unit commanders.

6.4.5. The FS, AOP and AOPT must be involved in mission planning on missions and operations where fatigue is likely to be a factor. They compare mission profile with operator circadian rhythm identifying phases of flight/operation where fatigue may be a factor. They plan ways to prevent or mitigate effects of fatigue ensuring mission/operation success. For aerial missions, focus is specifically on the critical phases of flight: take off, refueling, operational engagements, and landing.

6.4.6. The Fatigue Avoidance Scheduling Tool (FAST) on the web at: **http://novasci.ms11.net**/ and the Fly Awake Program, **http://flyawake.org**/ are useful tools available to aid the FS, AOPT, schedulers, and aircrew, manage fatigue and flying/work schedules (but require registration).

6.4.7. Non-pharmacologic interventions are the mainstay of fatigue countermeasures programs. Pharmacologic interventions are intended to be a last resort when all other measures have been exhausted. Flight Medicine establishes a program to ground test, dispense, and control pharmacological agents for fatigue management IAW AFI 48-123, AFI 11-202V3, and current AF policy. Further reference the Official Air Force Aerospace Medicine Approved Medications list located on the Kx under Flight Medicine / Medical Standards. *Note: For AFRC: Written plans must address the security, storage and distribution of controlled substances IAW AFI 41-209*

6.4.8. The SGP counsels, with the go-pill approval authority (wing or deployed commander), the medical utility of using go-pills for particular mission or mission set. The SGP will ensure appropriate non-pharmacological fatigue prevention strategies and operational countermeasures are utilized prior to concurring with operational go-pill use.

6.4.9. Go/no-go pill ground testing and operational use is voluntary. The FS offers ground testing for go/no-go pills to select eligible aircrew prior to use in operational setting. Documentation of successful ground testing or deferral is entered in the medical record of eligible aircrew. All aircrew are DNIF while ground testing both go and no-go pills.

6.4.10. Operational use of stimulants (go-pills) and sedatives (no-go pills) are IAW MAJCOM supplements to this instruction: (ACC for CAF, AMC for MAF, and AFSOC/CV policy letter for Battlefield Airmen) and the Official Air Force Aerospace Medicine Approved Medications list document on the Kx under Flight Medicine. The designated MAJCOMs will coordinate supplement development/revisions with AF/SG3P. Guidance on Kx remains the primary program resource until MAJCOM supplements are approved.

6.4.11. Approved medications and dosages are on the Official Air Force Aerospace Medicine Approved Medications list developed and maintained by AF/SG3P and located on the Kx under Flight Medicine/Medical Standards.

6.4.12. Eligibility criteria of a particular flight profile or SOD mission to use pharmacological stimulants and/or sedatives as operational countermeasure are determined by AF/A3 and vary based on aircraft and mission duration. ***Caution: it is very easy for Airmen using go/no-go pills to become operationally dependent on their use to the exclusion of all other non-pharmacological interventions. FSs must clinically supervise the use of any go/no-go medications and exercise careful judgment before dispensing. They are not intended to be a solution to manning shortages or to support a lifestyle of poor sleep habits or inappropriate prioritization of work and play activities.***

6.4.13. FSs provide eligible aircrew counseling regarding off label use of go-pills as an operational countermeasure, and obtain informed consent as required prior to prescribing them IAW 10 USC 1107(f), *Notice of Use of an Investigational New Drug or a Drug Unapproved for Its Applied Use*. Informed consent is required only once for each go-pill medication and dosage and must be documented in the Airman's medical record. (**Note:** see "Go Pills" on the Kx under Operational & Flight Medicine)

6.4.14. FSs report operational use of go-pills including adverse reactions during operational use to MAJCOM/SGP. Documentation and reporting methods are available on the AFMS Kx and should be used in the development of designated MAJCOM supplements to this

instruction. The MAJCOM/SGP will maintain record of go-pill use and provide annual summary to AFMSA/SG3PF.

6.4.15. FSs and Commanders may consider shifting the circadian rhythm of select aircrew to optimize alertness during planned missions and facilitate sleep during alert portion of circadian rhythm. Sleep aids during pre-mission crew rest (no-go medications) have been approved for use by select flying and non-flying special duty personnel where AF Form 1042 applies. See the Official Air Force Aerospace Medicine Approved Medications list document on the Kx under Flight Medicine for clarification.

6.4.16. Eligibility to operationally use pharmacologic sedatives requires appropriate ground testing and approval of local FS. Aircrew will declare themselves DNIF after use of sedative for the specified time as annotated in the Official Air Force Aerospace Medicine Approved Medications list and as instructed by the FS.

6.4.17. Multiple members from a squadron repeatedly being dispensed stimulants or sedatives for operational use, should trigger the associated SME to assess scheduling, personnel management and use of non-pharmacologic fatigue countermeasures to make sure they are being optimally executed prior to stimulant or sedative use.

6.5. Human System Integration (HSI).

6.5.1. HSI is "the integrated, comprehensive analysis, design and assessment of requirements, concepts and resources for system Manpower, Personnel, Training, Environment, Safety, Occupational Health, Habitability, Survivability and Human Factors" (AFPD 63-1/20-1, *Acquisition and Sustainment Life Cycle Management)* to "optimize total system performance, minimize total ownership costs, and ensure the system is built to accommodate the characteristics of the user population that will operate, maintain, and support the system" (DoDI 5000.02, *Operation of Defense Acquisition System*).

6.5.2. AME personnel contribute to the human system component (e.g., human performance, occupational health, force health protection, etc.) of the total system solution through the HSI process. AME personnel work with wing agencies and leadership to identify human performance limitations and explore potential countermeasures. Those countermeasures that can't be implemented at the wing level should be forwarded to the MAJCOM SGP for coordination with the line organizations responsible for total system performance IAW AFI 10-601, *Operational Capabilities Requirements Development*; AFI 63-101, *Acquisition and Sustainment Life Cycle Management*; and 63-131, *Modification Program Management* (i.e., the AF Form 1067 process).

6.6. Metrics: are IAW AFI 48-101, section 6.5.

Chapter 7

EMERGENCY RESPONSE AND DISASTER MANAGEMENT OPERATIONS

7.1. Objectives and desired effects.

7.1.1. The AF conforms to the National Response Framework (NRF) and conducts emergency response and disaster management operations IAW AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures.*

7.1.2. *For AFRC: At collocated bases, responsibilities are delineated in the host-tenant agreement. At stand-alone bases, these functions are handled by contractual agreements with local Fire & Emergency Services (FES).*

7.2. Organization and Functions.

7.2.1. The MTF(RMU) Medical Contingency Response Plan (MCRP) supports an Installation Emergency Management Plan (IEMP 10-2) IAW AFI 10-2501, and AFMAN 10-2502. FOMC personnel must be familiar with the MCRP and their roles within the plan.

7.2.2. The medical response to an incident must be structured using an all-hazards approach to effectively integrate with the overall installation response as encapsulated in seven key principles: Command, Safety, Communication, Assessment, Triage, Treatment, and Transport. The generic nature of these principles crosses service and organizational boundaries despite differences that may occur in detailed plans.

7.2.3. In using an all-hazards approach to prepare for any incident, the BE may be required to conduct surveillance, chemical, biological, radiological, nuclear, high-yield explosives (CBRNE) identification and quantification, and CBRNE health risk assessment and hazard communication.

7.3. Essential Functions.

7.3.1. **First Responders:** The FOMC will maintain emergency responder capability supporting installation flying operations and coordinate with other available first response capabilities.
Note: not applicable to ARC

7.3.2. First responders provide initial on-scene command. The first medical responder to an incident must co-locate with senior Fire and Police/Security commanders and/or Incident Commander (IC) as the Medical Advisor (MA) and be clearly recognizable. Further medical personnel arriving on scene must report to the MA for instructions if not previously issued by radio. The MA should be the most senior/experienced medical person on-scene. Role of the MA should be transferred upon the arrival of a more experienced medical responder depending on the circumstances of the incident and the expertise required. The MA will typically be the most senior/experienced FS.

7.3.2.1. In an incident requiring multiple medical response agencies, the senior medical responder may be designated as the Operation Section Chief, Division or Group Supervisor, or Branch Director by the IC. In a medical response only incident, the IC is typically the most senior/experienced medical person on-scene.

7.3.3. Transport: FOMCs support airfield operations responding to a variety of in-flight emergencies and airfield incidents. The type of vehicles required and the ability to respond adequately depends on the type of aircraft assigned and the spectrum of aircraft that visit the airfield. Installation location, mutual-aid response capability, and proximity to definitive care are factors that must be considered. These parameters form the basis of a risk assessment conducted by the SGP to determine level and adequacy of emergency medical response. Emergency Transport response time shall meet the requirements in DoDI 6055.06 , *DoD Fire Emergency Service Program*, Table E3.T1, minimum level of service objectives-operations section under *Emergency Medical*.

7.3.4. A transport vehicle must be able to transport a minimum of two first responders (NREMTs), one FS, and medical equipment/supply packs to any crash site within a 10 miles radius of the airfield over rough terrain.

7.3.5. Medical vehicle drivers responding to in-flight emergencies and airfield incidents must have a valid flight line drivers permit and be proficient with flight line driving during both day and night operations.

7.3.6. First Receivers: Some locations, require the FOMC have first receiver capability. This must be staffed with medical personnel with ATLS or pre hospital trauma life support (PHTLS) qualifications and knowledge of the Hospital Incident Command System (HICS).

7.4. Specialized Response. *Note: Not applicable for ANG. There are no full-time FSs available at ANG MDGs. Flyers are transported to AD MTFs for treatment at collocated bases or to local civilian hospitals for evaluation for non-collocated bases.*

7.4.1. CBRNE /HAZMAT Response: FOMC personnel must have correctly fitting PPE/IPE appropriate for the specific situation and have exercised using the equipment while performing their duties prior to responding.

7.4.2. Disaster Response. FOMCs must develop relationships and have plans that include coordination with local emergency services and an understanding of integration with these agencies.

7.4.3. **Aircraft Mishap Response:** FOMCs must review the Aircraft Mishap portion of the MCRP and ensure personnel are prepared to respond. Critical elements include:

7.4.3.1. Initial Response: site safety, treatment of injured, initial collection and preservation of evidence.

7.4.3.2. Evidence collection for involved personnel as directed by Wing Safety (SE).

7.4.3.3. Identify a local FS for the SIB (per base plan). The FS's primary duty is based on SIB requirements until released.

7.4.3.4. Make available SIB/MIB-associated healthcare records (medical, dental, MH)

7.4.3.5. Obtain 72 hour and 14 day histories

7.4.3.6. Obtain AFIP required toxicology and other relevant tests. Extent of testing depends on the nature of the mishap. Consult SGPs, AFIP, and the AF Safety Center FSs as needed.

7.4.3.7. The FOMC ensures proper aeromedical dispositions are accomplished for mishap personnel on flying/SOD.

7.4.3.8. Notification of medical leadership (SGP, SQ/CC, MDG/CC) and MAJCOM SGP

7.4.3.9. Mishap kits must be developed, maintained, and appropriately resourced. FOMC personnel must train and be familiar with the kit. FOMC personnel must review mishap response plans and inventory the mishap kit every 6 months at a minimum.

7.4.3.10. FOMCs will obtain written agreement with local coroner/medical examiner which governs possession of remains after aircraft mishap. This agreement must include authority to have a FS present at autopsies, and detail requirements for collection of AF mishap related specimens. **Note:** OCONUS sites will coordinate with MAJCOM ensuring this requirement is met under applicable Status of Forces Agreement.

7.4.4. **In-Flight Emergencies (IFEs):** FSs must be familiar with the management of routine in-flight emergencies, especially physiologic incidents. FSs must meet aircraft after in-flight emergencies with a physiologic incident to identify causes of symptoms and assess and document need for aircrew examination and/or treatment. *Note: <u>For AFRC</u>: Does not apply while in garrison.*

7.4.4.1. A FS must be available for in-flight emergency coverage during scheduled flying hours.

7.4.4.2. FSs must respond to IFEs when requested by Fire Chief/Wing Safety/Supervisor of Flying(SOF) and where there is a risk for physiologic incident including GLOC, hypoxia, aircrew disorientation, altered mental status, loss of cabin pressure at >20,000 ft., rapid decompression, smoke and fumes, or other physical symptoms or injuries reported by the aircrew.

7.4.4.3. Some IFEs can be monitored from the FOMC. Others require 4N0X1 and/or FS response.

7.5. Training: *Note: Not applicable to <u>ANG</u>. Training requirements are related to deployment training, unless assigned to a CERF-P or HRF.*

7.5.1. The FS and 4N0X1 are required to have Air Force Emergency Response Operations (AERO) Command & Control training. Recommend that the FS and 4N0X1 complete Air Force Incident Management Course (AFIMC).

7.5.2. All emergency responders should be trained on communications equipment (radio) use and communications protocol.

7.5.3. First responders must be trained and equipped for immediate response to expected hazards and environmental conditions.

7.6. Metrics: are IAW AFI 48-101, section 7.4.

Chapter 8

FLIGHT AND OPERATIONAL MEDICINE CLINIC TRAINING AND DEVELOPMENT

8.1. Objectives and desired effects. FOMC personnel are required to deliver the best aeromedical and operational support in garrison and while deployed. It is critical that FOMC personnel are skilled and proficient in their roles. MTF(RMU) leadership must allocate time and resources ensuring adequate training.

8.2. Individual FOMC AFSCs.

8.2.1. **FS (48R/G)**

8.2.1.1. **Initial Qualification Training (IQT)**

8.2.1.1.1. Physicians must successfully complete all three modules of the FS IQT course, the Aerospace Medicine Primary Course (AMP) provided by USAFSAM. (AMP 101- Fundamentals of Aerospace Medicine, AMP 201- Clinical/Practical Flight Medicine, AMP 202- Operational Medicine Workshops)

8.2.1.1.2. Graduates of IQT are considered Basic Mission Capable (BMC). They are awarded 48R1/G1 AFSC and Basic Flight Surgeon Wings. Survival, Escape, Resistance and Evasion (SERE) training is required per AFI 11-202 vol. 1, para. 2.1.1.5, *Aircrew Training*, should follow IQT, be conducted IAW AFI 16-1301 - *SERE Program*, and is not included in the AFSC upgrade requirements in para. 8.2.1.4. RAM program graduates and FSs assigned to AFSOC may require C-level training. Both B-level and C-level SERE training are expected to meet the requirements for participation in flying activities for theaters of operation per AF/A3O. Final concurrence lies with the assigned COCOM.

8.2.1.1.3. BMC FSs are authorized to work in the FOMC under the supervision plan developed by the MTF(RMU)/SGP. BMC FSs are not qualified for deployment as a FS or serve as medical member on a mishap investigation board (safety or legal officer). If the BMC FS is assigned against a Unit Task Code (UTC) he/she will be reported as "red" in SORTS until completion of Mission Qualification Training (MQT).

8.2.1.1.4. FSs assigned to an MTF(RMU) or line unit who are not Fully Mission Capable (FMC) (due to incomplete medical training requirements) require MAJCOM/SGP waiver to deploy IAW MAJCOM guidance. Approved waivers remain valid until the expected compliance date or 90 days from the approval date, whichever occurs first.

8.2.1.2. **Mission Qualification Training (MQT)**

8.2.1.2.1. After assignment to a FS billet and prior to deployment, the 48R1/G1 FS must complete MQT to become FMC and receive the 48R3/G3 AFSC upgrade IAW Air Force Officer Classification Directory. MQT may be initiated immediately upon completion of the AMP courses or at a later date if not immediately assigned to work in flight medicine clinic.

8.2.1.2.2. MQT must be completed within six months (Goal: 4 Months) from AMP course graduation when assigned to a FS billet, and periodic MQT training folder review between the FS and SGP is encouraged. *Note: For ANG, one year (goal 6 months), for AFRC, one year.*

8.2.1.2.3. When MQT requirements are completed and the MTF(RMU)/SGP certifies upgrade from 48R1/G1 (BMC) to 48R3/G3 (FMC), forward completed worksheet to MAJCOM/SGP or designated POC for AFSC upgrade approval via email. AFSC upgrade is complete after return of MAJCOM/SGP or designated POC endorsement to the unit. The unit uses an endorsed MQT worksheet to complete AF Form 2096, *Classification/On-The-Job Training Action* and files the worksheet in the FS's credential folder.

8.2.1.2.4. FMC FSs assigned against a UTC are reported "green" in SORTS after all MQT requirements are met. If a FS is missing formal training courses (i.e. ATLS, CPR, EMEDS), the FS are reported as "yellow". FSs reported as "red" are described above under IQT.

8.2.1.2.5. FS requirements for MQT and minimums for SGP to sign off as complete:

Table 8.1. MQT Requirements.

Requirements	Minimum Number for SGP Certification
Replacement Training Unit (RTU)	Once
Advanced Trauma Life Support Certification	Once
Occupational exams	Three (3)*
Annual flight physical examinations	Three (3)
Initial Flying Physicals	Two (2)*
Aircrew waiver package completion	Two (2)
Flight Medicine Working Group (1041 log meeting)	Four (4)
Occupational health shop visits	Two (2)
Public Health sanitation/food inspections	Two (2)
Aeromedical Council meetings	Two (2)
Deployment Availability Working Group	Once (1)
Occupational Environmental Health Working Group	Once (1)
Profile review as Profile Officer	Fifty (50)
Flight Surgeon sorties/flying hours	Sorties (4) & Hours (6)
Unrestricted flight surgeon privileges	Maintain
*MTF(RMU) SGP may certify with less than minimum observed if the individual demonstrates the requisite knowledge and skills to perform the function. MAJCOM/SGP must still approve the certification for upgrade per 8.2.1.2.3. above.	

8.2.1.3. Currency/Sustainment Training: AFSC 48X3 sustainment training is designed to ensure members with a fully qualified AFSC maintain currency of skills to perform duties both in garrison and in deployed settings. **Note**: Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, checklists.

8.2.1.4. Additional training. FSs may complete the following training courses to further medical and operational capabilities:

Table 8.2. Optional FS Training Courses.

Course	
Aircraft Mishap Investigation and Prevention Course	Once
Occupational Medicine Course	Once
Global Medicine Course	Once
Chief Aeromedical Services and Advanced FS Symposium (SGP Course)	Once
HAZMAT	Once
Advanced Clinical Concepts in Aeromedical Evacuation	Once
Military Tropical Medicine 1 and 2	Once
C-STARS – non surgeons	Once

8.2.1.5. Physicians who have been FMC and have not been assigned to a FS billet for greater than five years require requalification to FMC level as per **paragraph 8.2.1.2.5** and corresponding table.

8.2.1.6. FSs should maintain ATLS currency.

8.2.2. **PA (42G3)**

8.2.2.1. PAs will be assigned at some locations to assist FSs in the FOMC with aerospace medicine, primary care, occupational medicine and preventive medical services.

8.2.2.2. PAs assigned to the FOMC must complete AMP 201 at USAFSAM. This should be completed before arrival, but if not, must be accomplished within 6 months of arrival. Aerospace medicine privileges for PAs are dependent on completion of this training.

8.2.2.3. PAs are assigned to a 48X3 FS for professional supervision.

8.2.2.4. Supervision in medico-legal terms means oversight, control and direction of the services of a physician assistant, and includes but is not limited to:

8.2.2.4.1. Continuous direct communication either in person or by radio, telephone or other telecommunications between the PA and supervisor.

8.2.2.4.2. Active and continuing overview of PA's activities, ensuring supervisor's directions are implemented and the PA is supported in the performance of his/her duties.

8.2.2.4.3. If a PA is seeing a patient for the 3rd time for the same acute medical problem, a physician-preceptor will be consulted. This requirement does not include chronic stable diagnoses, which may be seen numerous times under a supervision plan that has been put in place to assist the PA.

8.2.2.4.4. Personal review of the PA's services by their supervisor through a face-to-face meeting with the PA at least weekly to ensure quality patient care, at a facility or practice location where the PA or supervisor perform services.

8.2.2.4.5. Review of charts and records of PAs on a regular basis ensuring quality patient care and written documentation at the facility or practice location where the PA or supervisor perform services is an integral part of PA development.

8.2.2.4.6. Delineation of a predetermined plan for emergency situations.

8.2.2.4.7. Designation of alternate/substitute 48X3 FSs in the absence of the supervisor.

8.2.2.4.7.1. Other physicians may participate in the day-to-day clinical oversight of PAs provided they are identified as a supervisor (or alternate as applicable):

8.2.2.4.7.2. Subsequently, this alternate maintains responsibility for oversight, control and direction of services provided by the PA, as well as having final responsibility for the care of patients and performance of the PA. The alternate performs the supervision as required above.

8.2.2.5. PAs will be privileged to provide primary care services IAW AFI 44-119. Specific privileges may be added to the privilege list after the supervisor and SGP determine such privileging is warranted. Privileges may include:

8.2.2.5.1. Certification of occupational-specific medical examination.

8.2.2.5.2. Personnel Reliability Program (PRP) administrative qualification.

8.2.2.5.3. Assessment of overseas clearance.

8.2.2.5.4. Evaluation and clearance for deployment.

8.2.2.6. Granting of additional privileges are done through process of review and mentoring during supervision.

8.2.2.7. Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, Checklists. **Note:** *PAs are physician extenders. They are not authorized to make continuation, DNIF, or return to duty aeromedical dispositions, Flying Physical Exams Certifications, or serve as MTF Profile Officers. PA's may evaluate and treat flyers and special duty personnel but aeromedical dispositions must be reviewed and approved by a FS at the time of the encounter. *Exception: HQ AF/SG delegates to the Medical Treatment Facility (MTF) Commander the authority to grant AFSOC Physician Assistants (PAs) working independently in support of Special Operations Command missions, aeromedical disposition privileges when deployed and without reasonable access to a FS preceptor, IAW HQ USAF/SG policy memorandum 05 Oct 2011.*

8.2.3. **FOMC Nurse Manager (46NX)**

8.2.3.1. Nurses assigned to the FOMC assist with aeromedical dispositions, administrative processing and operational support programs.

8.2.3.2. Nurses should attend the Flight Medicine Management Workshop (FMMW) on a space available basis within six months of assignment to FOMC. If not able to attend within six months then attend class when availability permits. FMMW provides a knowledge base for aeromedical programs and FOMC operations.

8.2.3.3. Nurses must maintain their AFSC specific training/certification, and Readiness Skills Verification Program (RSVP) training. Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, Checklists.

8.2.3.4. Nurses assigned to FOMC require SGP approval for additional duties outside of FOMC.

8.2.3.5. Nurse's roles in the FOMC include acting as FOMC nurse manager.

8.2.3.5.1. FOMC nurse managers improve overall clinic efficiency and ensure effective patient flow management. Actions include but are not limited to: assisting in FOMC patient care, medication refill management, active case management of FOMC enrolled patients including patients on AF Form 1041 log and with duty limiting conditions (must be familiar with FOMC patients with active AF Form 469), active tracking and management of FOMC specialty referrals, timely receipt and delivery of specialty referral correspondence to referring FOMC provider, aeromedical waiver and interim evaluation tracking and management, primary FOMC POC for patient complaints, assists with duty/on-call schedule development, active identification of FOMC flying and SOD personnel seen outside of FOMC ensuring continuity of care and timely aeromedical dispositions, ensuring occupational medicine program compliance, FOMC patient prevention counseling, tracking and ensuring follow-up of abnormal labs/studies.

8.2.4. **4N0X1.**

8.2.4.1. 4N0X1/C (IDMTs) assigned to FOMC will attend the FMMW within 6 months of assignment to receive the knowledge base of aeromedical programs and operations vital to success of FOMC mission. If not able to attend within six months then attend class when availability permits.

8.2.4.1.1. 4N0X1/C (IDMTs) assigned to FOMC or SME unit task code (UTC) should not deploy unless they have attended FMMW.

8.2.4.2. To obtain the necessary proficiency within the Flight and Operational Medicine, 4N0X1 should remain in the FOMC for at least 36 months before rotating to another area within the MTF(RMU). All rotations must be coordinated with the SGP, SQ/CC, MTF(RMU) Superintendent, and 4N0X1 Functional Manager. Premature rotations (based on the needs of the AFMS and local mission) must be approved by the MDG/CC.

8.2.4.3. 4N0X1 must maintain AFSC specific (upgrade, training and certification) and RSVP training. Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, Checklists.

8.2.4.4. Award of FOMC 4N0X1 SEI 470 requires attending the FMMW and a minimum of 6 months experience in the FOMC after completion of the FMMW.

8.2.4.5. Award of the SEI 470 is recommended to the MTF(RMU)/SGP from the senior FS, with concurrence from the senior 4N0X1, and will subsequently be annotated in MILPDS.

8.2.4.6. The flight (senior) 4N0X1 functional manager will have the SEI 470.

8.2.5. **4E0X1**

8.2.5.1. The Senior Manager 4EOX1(SrART) (enlisted/civilian/contractor) assigned to MSME works directly for the Flight Medicine/CC or MTF(RMU)/SGP for day to day operations and performs supervisory duty over personnel assigned to the MSME.

8.2.5.2. 4EOX1s (SrART) assigned to the MSME must complete required training specified by the PH Career-field Functional Manager and to have the knowledge base of aerospace medical programs and procedures.

8.2.5.3. 4E0X1s (SrART) assigned to the MSME remain assigned to MSME based on skill-level. 5-skill-level 4E0X1s (SrART) remain in MSME for 18-24 months and 7 skill-level technicians remain for 24-36 months prior to rotation. Rotations must be coordinated with the MTF(RMU)/SGP, MTF(RMU) Superintendent, and 4E0X1 Functional Manager. Premature rotations (based on the needs of the AFMS and local mission) must be approved by the MDG/CC.

8.2.5.4. 4E0X1s must maintain AFSC specific and RSVP training for career-field proficiency. Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, checklists.

8.2.6. **4A0X1**

8.2.6.1. 4A0X1 assigned to FOMC perform and direct patient management functions for the clinic.

8.2.6.2. 4A0X1 must maintain AFSC specific and RSVP training for career-field proficiency. Refer to the following website for the AFSC specific RSVPs. **https://kx.afms.mil**, under Readiness Skills Verification Program, checklists.

8.2.6.3. 4A0X1 Functions include:

8.2.6.3.1. Front Desk Receptionist/Records Manager

8.2.6.3.2. Greets patients.

8.2.6.3.3. Verifies patient identity and eligibility in Defense Eligibility Enrollment Reporting Systems (DEERS).

8.2.6.3.4. Checks in patients and enters patient information into the Armed Forces Health Longitudinal Technology Application (AHLTA).

8.2.6.3.5. Obtains third party collection information. (n/a for AFRC)

8.2.6.3.6. Identifies PRP patients.

8.2.6.3.7. Verifies patient demographics and directs patient to update in DEERS if required. Enters new contact information (minimum phone number) in AHLTA COMMENTS section.

8.2.6.3.8. Determines if visit is injury related; ensures AF Form 1488, *Daily Log of Patients Treated for Injuries* is completed. (n/a for AFRC)

8.2.6.3.9. Routes patient to appropriate location for their appointment.

8.2.6.3.10. Schedules follow-up patient appointments.

8.2.6.3.11. Assists with or tracks diagnostic results and routes them to the appropriate PCM/Specialist.

8.2.6.3.12. Trains, and assists 4N0X1 with proper completion and maintenance of paperwork and outpatient medical records.

8.2.6.3.13. Performs other patient administrative functions consistent with 4A0X1 skill set.

8.2.6.3.14. Assists in developing and maintaining provider templates.

8.2.6.3.15. Inputs appointment templates/schedules into AHLTA.

8.2.6.3.16. Coordinates referrals with the Referral Management Center (RMC). Obtains referral reports from RMC and routes to appropriate PCM. **Note**: Telephone-consultation is the method in which RMC notifies providers of results.

8.2.6.3.17. Performs clinic end of day processing.

8.2.6.3.18. Orders/re-stocks office supplies.

8.2.6.3.19. Coordinates documentation with appropriate clinical and support functions.

8.2.6.4. 4A0X1 as Unit PRP monitor:

8.2.6.4.1. Administers PRP program IAW DoDR 5210.42_AFMAN 10-3902.

8.2.6.4.2. Supports MTF(RMU)/CC and CMA administering the PRP.

8.2.6.4.3. Ensures unit personnel are trained (both initial and refresher training) on PRP.

8.2.6.4.4. Trains functional MTF(RMU)/PRP monitors.

8.2.6.4.5. Reviews installation's PRP roster with health records maintained at MTF(RMU) ensuring PRP health records are identified and screened.

8.2.6.4.6. Assists CMA in making PRP health notifications to the Unit/CC.

8.2.6.4.7. Conducts and documents self-inspection annually.

8.3. Squadron Medical Element (SME)-Specific Qualification Training.

8.3.1. Flying squadrons are responsible for orientation to the unit flying mission, deployment vulnerability and squadron inclusion in contingency plans.

8.3.2. MTF(RMU)/SGP is responsible for SME personnel orientation to local medical mission and equipment. Areas required within the first 90 days of assignment include:

8.3.2.1. Expeditionary Medical Support (EMEDS) system concept of operations and medical command and control

8.3.2.2. Medical intelligence resources available, emphasis on medical threats in potential deployment locations

8.3.2.3. Deployment sanitation, billeting, food &water assessment/security, and medical facilities site selection

8.3.2.4. Mishap/disaster response plans, checklists and equipment to include contents and proficiency with deployment kits and personal medical bags

8.3.2.5. Vector-borne disease surveillance and control

8.3.2.6. Operation of mobile and base station radios

8.3.2.7. Contracting

8.3.3. Maintenance of clinical skill sets, as well as regular and rigorous training for providing care in deployed austere/minimal medical facilities is part of an annual training plan. Sub-topics training for SMEs must be conducted at least monthly. The MAJCOM/SG may require additional specific training.

8.3.4. **SME FS-Specific**

8.3.4.1. SME FS must be fully credentialed, maintain unsupervised clinical privileges in the FOMC and meet FS MQT and currency requirements. (see section 8.2.1.2.5.) FS should recertify ACLS and ATLS IAW applicable standards.

8.3.4.2. Will maintain unit specific training requirements

8.3.4.3. Will maintain currency in other required medical and operational training, e.g. RSVP and Disaster Team Training. Refer to the following website for the AFSC specific RSVPs: **https://kx.afms.mil**, under Readiness Skills Verification Program, checklists.

8.3.5. **SME Technician-Specific.**

8.3.5.1. MTF(RMU)/SGP and senior 4N0X1, are responsible for scheduling and monitoring SME technician training. Training must be accomplished no later than 90 days after being assigned as a SME, unless previously accomplished and properly documented in Airman's training record.

8.3.5.2. Maintenance of AFSC training requirements/certifications and unit specific training requirements.

8.3.5.3. Should meet training requirements for SEI 470 prior to SME assignment. At a minimum, must have FMMW/FOMC operations training.

8.3.5.4. AFRC personnel will maintain current NREMT-B certification prior to performing SME technician duties in deployed environment.

8.3.5.5. Initial qualification training (IQT) for SME technicians must include:

8.3.5.5.1. Certification/currency as 4N0X1/C

8.3.5.5.2. Intravenous (I.V.) therapy and certification

8.3.5.5.3. Oxygen therapy

8.3.5.5.4. Four-wheel-drive modular ambulance and flight line driving (does not apply to ARC)

8.3.5.5.5. Satisfactory experience performing occupational health and safety assessments of industrial shops, flight line facilities, and other base/site support operations

8.3.5.5.6. Assessing proper waste disposal techniques (IDMT)

8.3.5.5.7. Water sampling, analysis, and purification to establish proper water quality (IDMT)

8.3.5.5.8. Food safety and quality inspections to evaluate food handling and storage procedures (IDMT)

8.3.5.5.9. Site selection criteria for bare-base medical facility

8.3.5.5.10. Operating mobile and base station radios

8.3.5.5.11. Administration and tracking of immunizations

8.3.5.5.12. Disease and Injury Surveillance, including use of current deployment-medicine Disease Non-Battle Injury (DNBI) software such as AHLTA-T or future iterations of similar software mechanisms of DNBI study

8.3.5.6. NREMT-B/P recertification is mandatory for 4N0X1/C technicians assigned to SME positions and must be accomplished IAW 4N0X1/C CFETP.

8.3.5.7. Medical Unit Readiness Training (MURT) requirements should be accomplished IAW applicable directives, but may be met by operational deployments during the preceding year. Training and/or credit for having met the requirement through deployment should be annotated in SME's 6-part training folder or electronic training record.

8.4. Metrics. Metrics are IAW AFI 48-101, section 2.4 and AFI 44-103, Chapter 2.

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AASD—Aviation and Aviation Related Special Duty

ACC—Air Combat Command

ACS—Aeromedical Consultation Service

ACLS—Advanced Cardiac Life Support

AERO—Air Force Emergency Response Operations

AF—Air Force

AFIMC—Air Force Incident Management Course

AFIMS—Air Force Incident Management System

AFMS—Air Force Medical Service

AF/A3O—Director of Operations

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFSAS—Air Force Safety Automated System

AF/SG—Surgeon General

AF/SG3—Assistant Surgeon General, Health Care Operations

AF/SG3P—Chief, Aerospace Medicine Policy and Operations

AF/SG3PA—Aerospace Medicine Division

AFSOC—Air Force Special Operations Command

AFOSH—Air Force Occupational Safety and Health

AIMWTS—Aeromedical Information Management Waiver Tracking System

ALC—Assignment Limitation Code

AMC—Air Mobility Command

AMC—Aerospace Medicine Council

AME—Aerospace Medicine Enterprise

ANG—Air National Guard

AOP—Aerospace and Operational Psychologist

AOPT—Aerospace and Operational Physiology Team

AOR—Area of Responsibility

ARC—Air Force Reserve Component (AFRC, ANG, IMA)

ASF—Aeromedical Staging Facility

ASIMS—Aeromedical Services Information Management System

ATC—Air Traffic Control

ATLS—Advanced Trauma life Support

BE—Bioenvironmental Engineering

BEE—Bioenvironmental Engineer

BLS—Basic Life Support

BMC—Basic Mission Capable

CAF—Combat Air Forces

CBRNE—Chemical, Biological, Radiation, Nuclear, High Explosive

CDC—Centers for Disease Control and Prevention

CEW—Civilian Expeditionary Workforce

CFETP—Career Field Education and Training Plan

CFM—Career Field Functional Manager

CHOP—Community Health Operations Program

CMA—Competent Medical Authority

CME—Continuing Medical Education

COCOM—Combatant Commander

CPR—Cardio Pulmonary Resuscitation

CPS—Civilian Personnel Services

CSARME—Combat Search and Rescue Medical Element

DAWG—Deployment Availability Working Group

DCS—Decompression Sickness

DMS—Director of Medical Services

DNIF—Duties Not Involving Flying

DoD—Department of Defense

DoDI—Department of Defense Instruction

DRF—Disaster Response Force

DSCA—Defense Support to Civil Authorities

EAP—Employee Assistance Program

EEO—Equal Employment Opportunity

EPR—Enlisted Performance Report

ESOHC—Environmental Safety and Occupational Health Council

FAA—Federal Aviation Administration

FAST—Fatigue Avoidance Scheduling Tool

FECA—Federal Employment Compensation Act

FM—Flight Medicine

FMC—Fully Mission Capable

FMP—Flight Medicine Physicians (contract)

FMMW—Flight Medicine Management Workshop

FMWG—Flight Medicine Working Group

FOMC—Flight and Operational Medicine Clinic

FOMP—Flight and Operational Medicine Program

FS—Flight Surgeon

GBC—Ground Based Controller

GSU—Geographically Separated Unit

HAF—Headquarters Air Force

HAWC—Health and Wellness Center

HICS—Hospital Incident Command System

HIPAA—Health Insurance Portability and Accountability Act

HIV—Human Immunodeficiency Virus

HSI—Human Systems Integration

HUD—Heads Up Display

IC—Incident Commander

ICPA—Installation Compensation Program Administrator

IDMT—Independent Duty Medical Technician

IEMP—Installation Emergency Management Plan

IGRA—Interferon-Gamma Release Assay

IMA—Individual Mobilization Augmentee

IOEMC—Installation Occupational and Environmental Medicine Consultant

IPE—Individual Protective Equipment

IQT—Initial Qualification Training

IRC—Instrument Refresher Course

JAG—Judge Advocate General

LEP—Laser Eye Protection

LOE—Letter of Evaluation

LSMFT—Limited Scope Medical Treatment Facility

LTBI—Latent Tuberculosis Infection

MA—Medical Advisor

MAF—Mobility Air Forces

MAJCOM—Major Command

MAS—Medical Aid Station

MCRP—Medical Treatment Facility Medical Contingency Response Plan

MDG—Medical Group

MDG/CC—Medical Group Commander RDS**—**Records Disposition Schedule

MDS—Mission Design Series

MEO—Military Equal Opportunity

METALS—Mission Essential Task/Activities for Line Support

MFS—Medical Flight Screening

MILPDS—Military Personnel Data System

MMWR—Morbidity and Mortality Weekly Report

MOA—Memorandum of Agreement

MOU—Memorandum of Understanding

MQT—Mission Qualification Training

MRM—Maintenance Resource Management

MRO—Medical Review Officer

MROCC—Medical Review Officer Certification Council

MSME—Medical Standards Management Element

MTF(RMU)—Medical Treatment Facility (Reserve Medical Unit)

MTL—Master Task List

NATO—North Atlantic Treaty Organization

NGB—National Guard Bureau

NREMT—National Registry of Emergency Medical Technicians

NREMT-B—National Registry Emergency Medical Technician Basic

NRF—National Response Framework

OEHWG—Occupational and Environmental Health Working Group

OEM—Occupational Environmental Medicine

OIC—Officer in Charge

OJT—On the Job Training

OM—Occupational Medicine

OPM—Office of Personnel Management

OPR—Officer Performance Report

OPR—Office of Primary Responsibility

OSHA—Occupational Safety and Health Administration

OWCP—Office of Worker's Compensation Programs

PAR—Population at Risk

PCM—Primary Care Manager

PEPP—Physical Examination Processing Program

PH—Public Health

PHEO—Public Health Emergency Officer

PHTLS—Pre-Hospital Trauma Life Support

PIMR—Preventative Health Assessment and Individual Medical Readiness

PMCC—Preventive Medicine Clinical Consultant

POC—Point of Contact

POW—Prisoner of War

POWER—Protecting Our Workers and Ensuring Re-employment

PPE—Personal Protective Equipment

PRP—Personnel Reliability Program

PSP—Presidential Support Program

RAPCON—Radar Approach Control

RMU—Reserve Medical Unit

ROBD—Reduced Oxygen Breathing Device

RON—Remain Overnight

RPA—Remotely Piloted Aircraft

RSVP—Readiness Skills Verification Program

RTF—Response Task Force

SEG—Similar Exposure Groups

SEI—Special Experience Identifier

SGP—Chief, Aerospace Medicine

SHARE—Safety Health and Return to Employment

SIB—Safety Investigation Board

SME—Squadron medical Element

SOD—Special Operational Duty

SOF—Special Operations Forces

SrART—Senior Air Reserve Technician

STANAG—Standardization Agreement (NATO)

STI—Sexually Transmitted Infections

TAOS—Team Aerospace Operational Symposium

TB—Tuberculosis

TDY—Temporary Duty

TIG—Technical Implementation Guide

UCMJ—Uniform Code of Military Justice

UTC—Unit Task Code

US—United States